TOWNSHIP OF JACKSON
DEPARTMENT OF ADMINISTATION
DIVISION OF PERSONNEL

EMPLOYEE DATA FORM
(Please Print)

( ) New Employee ( ) Current Employee Update

Name: _____ Gender: ( ) Male ( ) Female

Address: _____ Date of Birth: _____

_____ Marital Status: ( ) S ( ) M ( ) D ( ) W

Home Phone: ( ) _____ Cell Phone: ( ) _____ _____

Email Address: _____

Emergency Contact:
_____

Name: _____ _____ Relationship: _____

Address: _____

Best Way To Contact: [ ]Home Phone: ( )_____ [ ] Cell Phone: ( ) _____

Dependent Information:

Name of Dependent	***Birth Date***	***Dependent SS#***	***Student (Y) or (N)***

EMPLOYEE'S SIGNATURE: _____ ***DATE:*** _____

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)					
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)					

Additional Information

☐ 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		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** 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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**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.
		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		
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				

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.

CONSCIENTIOUS EMPLOYEE PROTECTION ACT
"WHISTLEBLOWER ACT"
2021

I HAVE RECEIVED THE CONSCIENTIOUS EMPLOYEE PROTECTION ACT "WHISTLEBLOWER ACT" ANNUAL NOTICE IN ACCORDANCE WITH N.J.S.A.34:19-7

NAME: _____

SIGNATURE: _____

DEPARTMENT: _____

DATE: _____

PLEASE COMPLETE AND SUBMIT TO:
BARBARA L. WELDON, PERSONNEL OFFICER
DIVISION OF PERSONNEL

TOWNSHIP OF JACKSON
DEPARTMENT OF ADMINISTRATION
DIVISION OF PERSONNEL

ACKNOWLEDGEMENT OF RECEIPT
EMPLOYEE HANDBOOK

I acknowledge that I have received a copy of Township of Jackson Employee Handbook. I agree to review the handbook and should there be any policy or provision in the Handbook that I do not understand, I will seek clarification from my supervisor, Department Head, or the Personnel Officer.

I understand that Jackson Township is an "at will" employer and consistent with applicable Federal and State law, including the New Jersey Civil Service Act, as well as applicable bargaining unit agreements, employment with the Township is not for a fixed term or definite period and may be terminated at the will of either party, with or without cause, and without prior notice.

No supervisor or other representative of the Township has the authority to enter into any agreement for employment for any specified period of time, or to make any agreement contrary to the above. In addition, I understand that this Handbook states the Township's personnel policies in effect on the date of publication and understand that these policies are continually evaluated and may be amended, modified or terminated at any time.

I understand that nothing contained in the Handbook may be construed as creating a promise of future benefits or a binding contract with the Township for benefits or for any other purpose

Please sign and date this receipt and return it to the Personnel Officer.

Date: _____

Print Name: _____

Signature: _____

JACKSON TOWNSHIP

OPTIONAL AFFIRMATIVE ACTION INFORMATION

The information on this form is requested for compliance with federal/state employment reporting regulations relative to the affirmative action program. **Completion of this form is optional.** Providing or refusing to provide this information will not adversely affect your application for employment. This information cannot and **will not** be used for making employment recommendations. The information on this form is requested solely for the purpose of the affirmative action program.

Federal law provides for affirmative action efforts for minority groups. If you wish to identify yourself as a member of one of these groups, please indicate below.

Gender: [ ] Male [ ] Female

Race:

[ ] White **not of Hispanic origin:** A person having origins in any of the original people of Europe, North Africa or the Middle East.

[ ] **Black, not of Hispanic origin:** A person having origins in any of the Black racial group in Africa.

[ ] **Hispanic:** A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

[ ] **Asian or Pacific** Islander: A person having origins in any of the original people of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area include, for example, China, Japan, the Philippine Islands, and Samoa.

[ ] **American Indian or Alaskan native:** A person having origins in any of the original people of North America, and who maintains cultural identification through tribal affiliation or community recognition.

Signature _____

Print Name _____

Social Security Number _____

Date _____

WE ARE AN AFFIRMATIVE ACTION/EQUAL OPPORTUNITY EMPLOYER.

We comply with Titles VI and VII of the Civil Rights Act of 1964, amended; the Equal Pay Act of 1963, as amended; the Age Discrimination in Employment Act of 1967, as amended, the Age Discrimination Act of 1975; the Pregnancy Discrimination Act; the Rehabilitation Act of 1973; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Title IX of the Educational Amendments of 1972; and the American with Disabilities Act of 1990. Any inquires or charges of violation concerning the application of these policies should be directed to Personnel Director of Jackson Township. Requests for accommodation of a disability should be directed to Personnel Department of Jackson Township.

Acknowledgment of Receipt of Gender Equity Notification

I received a copy of the gender equity notification on the date listed below.
I have read it and I understand it.

_____ _____

Name (signature) Name (print)

_____

Date

NEW JERSEY DEPARTMENT OF
LWD
LABOR AND WORKFORCE DEVELOPMENT
nj.gov/labor

Right to be Free of Gender Inequity
or Bias in Pay, Compensation, Benefits
or Other Terms and Conditions of Employment

New Jersey and federal laws prohibit employers from discriminating against an individual with respect to his/her pay, compensation, benefits, or terms, conditions or privileges of employment because of the individual's sex.

FEDERAL LAW

Title VII of the Civil Rights Act of 1964 prohibits employment discrimination based on, among other things, an individual's sex. Title VII claims must be filed with the United States Equal Employment Opportunity Commission (EEOC) before they can be brought in court. Remedies under Title VII may include an order restraining unlawful discrimination, back pay, and compensatory and punitive damages.

The Equal Pay Act of 1963 (EPA) prohibits discrimination in compensation based on sex. EPA claims can be filed either with the EEOC or directly with the court. Remedies under the EPA may include the amount of the salary or wages due from the employer, plus an additional equal amount as liquidated damages.

Please be mindful that in order for a disparity in compensation based on sex to be actionable under the EPA, it must be for equal work on jobs the performance of which requires equal skill, effort, and responsibility, and which are performed under similar working conditions.

There are strict time limits for filing charges of employment discrimination. For further information, contact the EEOC at 800-669-4000 or at www.eeoc.gov.

NEW JERSEY LAW

The New Jersey Law Against Discrimination (LAD) prohibits employment discrimination based on, among other things, an individual's sex. LAD claims can be filed with the New Jersey Division on Civil Rights (NJDCR) or directly in court. Remedies under the LAD may include an order restraining unlawful discrimination, back pay, and compensatory and punitive damages.

Another State law, N.J.S.A. 34:11-56.1 et seq., prohibits discrimination in the rate or method of payment of wages to an employee because of his or her sex. Claims under this wage discrimination law may be filed with the New Jersey Department of Labor and Workforce Development (NJDLWD) or directly in court. Remedies under this law may include the full amount of the salary or wages owed, plus an additional equal amount as liquidated damages.

Please be mindful that under the State wage discrimination law a differential in pay between employees based on a reasonable factor or factors other than sex shall not constitute discrimination.

There are strict time limits for filing charges of employment discrimination. For more information regarding LAD claims, contact the NJDCR at 609-292-4605 or at www.njcivilrights.gov. For information concerning N.J.S.A. 34:11-56.1 et seq., contact the Division of Wage and Hour Compliance within the NJDLWD at 609-292-2305 or at http://lwd.state.nj.us.

This notice must be conspicuously displayed.

NEW JERSEY DEPARTMENT OF
LWD
LABOR AND WORKFORCE DEVELOPMENT
nj.gov/labor

OneSource

Your Employee Assistance Benefit

The Employee Assistance Program (EAP) is a benefit that provides counseling services for those times when you and your family are faced with difficulties in life. Our licensed, professional staff are available to consult with you on any issue that affects your peace of mind or interferes with your day-to-day activities.

For example:

- **Family Concerns** – Parent/Child conflicts, Aging Parents
- **Marital/Couple Issues** – Communication Issues, Divorce
- **Stress** - -Anxiety, Depression, Sleep Difficulties, Headaches
- **Addiction Issues** – Drugs, Alcohol Abuse, Gambling, Sexual
- **Occupational Issues** – Job Performance, Co-Worker Conflict, Poor Morale
- **Lifestyle Changes** – Mid-Life Crises, Death

Why Do I Have This Benefit?

Jackson Township believes in supporting its employees by offering immediate, effective help when you need it. The benefit also covers your immediate family.

Your One Source EAP Provides:

- ✓ **Confidential** counseling with no co-pay
- ✓ **Six free counseling sessions** per year for you and each of your immediate family members, including children up to age 26
- ✓ **National Provider Network** – If a student attending college far from home requires counseling, One Source EAP has providers close by, within 20 minutes or 20 miles in every state

How Do I Use My EAP Benefit?

- Call One Source EAP at **1-800-300-0628**. A Central Access Specialist will answer your call, 24 hours a day, 7 days a week, 365 days a year.
- The Central Access Specialist will ask you a few questions to assess your situation, then identify providers that can help with the topic you wish to discuss.
- You'll make an appointment with your preferred provider.
- Call the Access Center and give them the date of your first appointment with the counselor you've chosen.
- Should you require additional sessions beyond the six free sessions, contact your health insurance carrier for pre-approval. You will then incur co-pays under your health insurance benefit.
- Visit our website at https://www.rwjbh.org/one-source-eap/ or use the QR code below to access additional information and resources.

One Source Employee Assistance Program | RWJBarnabas HEALTH

HA-0889-0220

State Health Benefits Program (SHBP)

LOCAL GOVERNMENT ACTIVE EMPLOYEE GROUP

HEALTH BENEFITS ENROLLMENT AND/OR CHANGE FORM

1. MEMBER INFORMATION — Last Name | First | MI

Gender	Birth Date	Social Security Number	Marital Status*
	/ /	— —	

Phone Number: ( )

Email Address

Street Address | City | State | Zip

2. EMPLOYMENT STATUS ☐ Full Time ☐ National Guard

3. REASON FOR APPLICATION (Check one)

☐ New Enrollment ☐ Transfer
☐ Open Enrollment ☐ Loss of Coverage
☐ Adding Dependents ☐ Deleting Dependents
☐ Other

Reason_____

Date of Event _____/_____/_____

4. TYPE AND LEVEL OF COVERAGE

Level	Health	Rx
☐ Single	☐	☐
☐ Parent/Child	☐	☐
☐ Member/Spouse/Civil Union	☐	☐
☐ Member/Domestic Partner	☐	☐
☐ Family	☐	☐

DIVISION USE ONLY

Effective Dates — Event Reason:
H _____/_____/_____
Rx _____/_____/_____

EMPLOYER CERTIFICATION
(See Instructions on reverse)

Employer Name _____

Location # (State Monthly)

10/12 - month employee (Enter 10 or 12)

MEMBER ACTION

☐ New Enrollment ☐ Transfer

Date Employment Began
_____/_____/_____

☐ Return from Leave of Absence
_____/_____/_____

Signature of Certifying Officer

Phone Number *Date Mailed*

5. HEALTH PLAN — (Check one box only)

☐ OMNIA Health Plan ☐ NJ DIRECT/ NJ DIRECT 2019* ☐ NJ DIRECT10 ☐ NJ DIRECT15 ☐ NJ DIRECT1525
☐ NJ DIRECT2030 ☐ NJ DIRECT2035 ☐ Horizon HMO ☐ NJ DIRECT HD1500* ☐ NJ DIRECT HD4000

For HD Plans only – Health Savings Account (HSA)

☐ I wish to establish an HSA at this time and understand that I will be contacted to establish banking. By applying for and funding my HSA I represent that I:

1) am covered under a High Deductible Health Plan (HDHP);
2) am not covered by any other non-HDHP product;
3) am not covered by Medicare; and
4) cannot be claimed as a dependent on another person's tax return.

☐ I am not enrolling in an HSA at this time and understand that if I choose to at a later date, I must contact my health plan.

6. DEPENDENT INFORMATION — List all eligible dependents and attach required proof of dependency documents*

☐ **Additional sheets attached. Any dependents not listed will be removed.**

Eligible Dependents Last Name, First Name	Social Security No.	Circle Relationship	Birth Date	Gender
	— —	Spouse / Civil Union / Domestic Partner	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	
	— —	Child (Natural, Adopted, Foster, Step, Legal Ward)	/ /	

***See Instructions page for detailed information and mailing address**

MEMBER CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the in-network benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require. **Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A.17:33A-6c.

7. Member Signature _____ **Date** _____/_____/_____

HB-0840-0120

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or overage children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Any dependents not listed on the application will not be covered.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate and a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. If tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both spouses and is received at the same address.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate and a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. If tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both partners and is received at the same address.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under P.L. 2003, c. 246, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP - or SEHBP - participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners and a copy of the front page of the employee/retiree's N.J. tax return* from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. If tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) that includes the names of both partners and is received at the same address.
CHILDREN	A subscriber's child until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	**Natural or Adopted Child** – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. **Step Child** – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. **Legal Ward, Grandchild, or Foster Child** – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP; (2) the child continues to be disabled; (3) the child is unmarried or does not enter into a civil union or domestic partnership; and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate child type (as noted above) and a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate child type (as noted above), and a copy of the front page of the child's federal tax return* (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

*You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. To obtain copies of the documents listed above, contact the office of the town clerk in the city of the birth, marriage, etc., or visit these websites: ***www.vitalrec.com*** or ***www.studentclearinghouse.org*** Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: ***www.nj.gov/health/vital/index.shtml***

DELTA DENTAL®

DENTAL ENROLLMENT FORM

03080

☐ Delta Dental Premier® Program (Clerical) 03080-00001

☐ Delta Dental Premier® Program (Dept Heads) 03080-00002

☐ Delta Dental Premier® Program (DPW) 03080-00003

☐ Delta Dental Premier® Inventive Program (PBA) 03283-00004

Name of Employer

Township of Jackson

Effective Date of Coverage

GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

Name (Last) (First) (Middle)	Date of Birth	Social Security Number
	____/____/____	___-___-____

Street Address	City, State, Zip	County

Date of Employment	Type of Coverage	Marital Status	Home Telephone
____/____/____	☐ Single ☐ Parent/Child ☐ Husband/Wife ☐ Parent/Children ☐ Family	☐Single ☐Married ☐Divorced/Separated	( )

Enrollment	First Name - Last Name	Social Security Number	Date of Birth	Full-Time Student
Subscriber		____-____-____	/ /	
Spouse*		____-____-____	/ /	
Dependent		____-____-____	/ /	☐ Yes ☐ No
Dependent		____-____-____	/ /	☐Yes ☐No
Dependent		____-____-____	/ /	☐Yes ☐No
Dependent		____-____-____	/ /	☐Yes ☐No

* If spouse has other dental coverage, please list name and address of employer and other carrier:

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Subscriber Signature _____ Date _____

Delta Dental Use Only

Entered _____

Operator # _____

Claims Mailing address – PO Box 222 Parsippany, NJ 07054
Customer Serv. number – (800) 452-9310
Web Site – www.deltadentalnj.com

EyeMed VISION CARE® COLE MANAGED VISION

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Location Code	Division Code	Client Co Code	Effective Date
9698051	Township of Jackson				

EMPLOYEE INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Sex ☐ M ☐ F	Member ID	Last Name (Employee or subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number
☐A ☐T ☐C	Sex ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth	Social Security Number

Employee Signature: _____ Date: _____

Instructions:

Employer name: Legal name of the employer.
Group Number: Provided by EyeMed or EyeMed representative.
Location code: Optional field for employers to track multiple locations.
Effective date: Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of name, employee address or employee phone.

Once you elect EyeMed vision coverage, you cannot cancel for a 12-month period based upon your enrollment date.
Deductions are adjusted according to payroll frequency.

take care®
by WageWorks

Salary Redirection Agreement (SRA)

PLEASE PRINT. All information is required or your enrollment cannot be processed.

Employer _____ Social Security Number

Employee Name (First, Last)

Date of Birth (MM-DD-YYYY) Date Hired (MM-DD-YYYY)

Home (Street) Address APT.

City State Zip

Home Phone Email

By enrolling in the plan you will receive a take care Card to pay for qualified plan expenses. If you would also like to receive a take care Card for your spouse or a dependent (must be 18 years old) please provide their name here. (First Name, Last Name)

Employer to complete or enrollment cannot be processed.

Plan year start (MM/DD/YY) ___/___/___ and end ___/___/___ First payroll start date ___/___/___

No. of Pays _____ Dept. _____

OPTION 1 Health Care Account

☐ **YES** I elect to contribute $ (before taxes) for the PLAN YEAR, which is $ per pay period to fund my account that pays qualified out-of-pocket health care expenses that are not covered by my employer's health plan or any other health plan.

☐ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 2 Dependent Care Account

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

☐ **YES** I elect to contribute $ (before taxes) for the PLAN YEAR, which is $ per pay period to fund my account that pays qualified dependent day care or elder care expenses.

☐ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 3 Agreement to Save Taxes on Insurance Premiums

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

☐ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

OPTION 4 Additional Benefit

(please insert description provided by your HR Department, if applicable) _____

☐ **YES** I elect to contribute $ (before taxes) for the PLAN YEAR, which is $ per pay period for funding reimbursement of this additional benefit outlined by my Human Resources Department.

☐ **NO** I decline this option for this plan year and understand that I will lose all tax savings that I could receive as a participant.

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

USE OF PERSONAL INFORMATION – In addition to and without limiting in any way the rights my employer, the Plan, their service provider and their respective agents, employees, subcontractors, and assigns may have under applicable state or federal law or regulation, I hereby specifically authorize those parties to use my personal information (including, but not limited to benefit elections, wages, employment status, number of dependents, marital status and health and dependent child care information) as is reasonably required to administer the Plan (including evaluating and processing requests for payment of claims) and detecting and preventing fraud or misrepresentation. I further authorize my employer, the Plan, their service provider and their respective agents, employees, subcontractors and assigns to further disclose any such personal information as is reasonably required for such purposes. I hereby expressly waive and release any claims related to the use, disclosure or release of such information so long as the information is used in furtherance of Plan administration or to detect or prevent fraud or misrepresentation.

Employee signature _____ Date _____

HealthEquity®

SPEND SMARTER. SAVE MORE ON HEALTHCARE.

An FSA empowers you to keep more of your hard-earned money. Plan your spending, know the rules and unlock amazing tax savings.

WHAT IS A FLEXIBLE SPENDING ACCOUNT?

FSAs are tax-advantaged accounts that let you use pre-tax dollars to pay for eligible medical expenses. You can use an FSA to save on average 30 percent[1] on healthcare costs. Don't think of it as money deducted from your paycheck—think of it as money added to your wallet.

Make your elections

Once you choose an annual contribution, your employer will deduct that amount pre-tax in equal parts from each paycheck. (26 pays per year)

FSA 2023 IRS contribution limits

$2,850

Think Beyond the Doctor's Office

Because of the tax savings on contributions, you can save an average of 30% on qualified medical expenses, including but not limited to:

Acne Medicine
Ambulance
Contact Lenses[Rx]
Dental Cleanings
Disposable Face Masks
Eyeglasses[Rx]
Eye Surgery
Hearing Aids
Motorized Wheelchair
Prescriptions[Rx]
X-Rays
Allergy Medicines

Form **NJ-W4**
(7-18, R-14)

State of New Jersey - Division of Taxation
Employee's Withholding Allowance Certificate

1. SS#	2. **Filing Status: (Check only one box)**
Name	1. ☐ Single
Address	2. ☐ Married/Civil Union Couple Joint
City / State / Zip	3. ☐ Married/Civil Union Partner Separate
	4. ☐ Head of Household
	5. ☐ Qualifying Widow(er)/Surviving Civil Union Partner

3. If you have chosen to use the chart from instruction A, enter the appropriate letter here	3.
4. Total number of allowances you are claiming (see instructions)	4.
5. Additional amount you want deducted from each pay	5. $
6. I claim exemption from withholding of NJ Gross Income Tax and I certify that I have met the conditions in the instructions of the NJ-W4. If you have met the conditions, enter "EXEMPT" here . . .	6.

7. Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or entitled to claim exempt status.

Employee's Signature — Date

Employer's Name and Address — Employer Identification Number

BASIC INSTRUCTIONS

Line 1 Enter your name, address and social security number in the spaces provided.

Line 2 Check the box that indicates your filing status. If you checked Box 1 (Single) or Box 3 (Married/Civil Union Partner Separate) you will be withheld at Rate A.

Note: If you have checked Box 2 (Married/Civil Union Couple Joint), Box 4 (Head of Household) or Box 5 (Qualifying Widow(er)/Surviving Civil Union Partner) and either your spouse/civil union partner works or you have more than one job or more than one source of income and the combined total of all wages is greater than $50,000, see instruction A below. If you do not complete Line 3, you will be withheld at Rate B.

Line 3 If you have chosen to use the wage chart below, enter the appropriate letter.

Line 4 Enter the number of allowances you are claiming. Entering a number on this line will decrease the amount of withholding and could result in an underpayment on your return.

Line 5 Enter the amount of additional withholdings you want deducted from each pay.

Line 6 Enter "EXEMPT" to indicate that you are exempt from New Jersey Gross Income Tax Withholdings, if you meet one of the following conditions:

- Your filing status is **SINGLE or MARRIED/CIVIL UNION PARTNER SEPARATE** and your wages plus your taxable nonwage income will be $10,000 or less for the current year.
- Your filing status is **MARRIED/CIVIL UNION COUPLE JOINT**, and your wages combined with your spouse's/civil union partner's wages plus your taxable non wage income will be $20,000 or less for the current year.
- Your filing status is **HEAD OF HOUSEHOLD** or **QUALIFYING WIDOW(ER)/SURVIVING CIVIL UNION PARTNER** and your wages plus your taxable nonwage income will be $20,000 or less for the current year.

Your exemption is good for **ONE** year only. You must complete and submit a form each year certifying you have no New Jersey Gross Income Tax liability and claim exemption from withholding. If you have questions about eligibility, filing status, withholding rates, etc. when completing this form, call the Division of Taxation's Customer Service Center at 609-292-6400.

Instruction A - Wage Chart

This chart is designed to increase withholdings on your wages, if these wages will be taxed at a higher rate due to inclusion of other wages or income on your NJ-1040 return. **It is not intended to provide withholding for other income or wages.** If you need additional withholdings for other income or wages use Line 5 on the NJ-W4. This Wage Chart applies to taxpayers who are married/civil union couple filing jointly, heads of households or qualifying widow(er)/surviving civil union partner. **Single individuals or married/civil union partners filing separate returns do not need to use this chart.** If you have indicated filing status #2, 4 or 5 on the above NJ-W4 and your taxable income is greater than $50,000, you should strongly consider using the Wage Chart. (See the Rate Tables on the reverse side to estimate your withholding amount).

HOW TO USE THE CHART

1) Find the amount of your wages in the left-hand column.

2) Find the amount of the total for all other wages (including your spouse's/civil union partner's wages) along the top row.

3) Follow along the row that contains your wages until you come to the column that contains the other wages.

4) This meeting point indicates the Withholding Table that best reflects your income situation.

5) If you have chosen this method, enter the "letter" of the withholding rate table on Line 3 of the NJ-W4.

NOTE: If your income situation substantially increases (or decreases) in the future, you should resubmit a revised NJ-W4 to your employer.

THIS FORM MAY BE REPRODUCED

WAGE CHART

Total of All Other Wages		0 10,000	10,001 20,000	20,001 30,000	30,001 40,000	40,001 50,000	50,001 60,000	60,001 70,000	70,001 80,000	80,001 90,000	OVER 90,000
YOUR WAGES	0 10,000	B	B	B	B	B	B	B	B	B	B
	10,001 20,000	B	B	B	B	C	C	C	C	C	C
	20,001 30,000	B	B	B	A	A	D	D	D	D	D
	30,001 40,000	B	B	A	A	A	A	A	E	E	E
	40,001 50,000	B	C	A	A	A	A	A	E	E	E
	50,001 60,000	B	C	D	A	A	A	E	E	E	E
	60,001 70,000	B	C	D	A	A	E	E	E	E	E
	70,001 80,000	B	C	D	E	E	E	E	E	E	E
	80,001 90,000	B	C	D	E	E	E	E	E	E	E
	over 90,000	B	C	D	E	E	E	E	E	E	E

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

2023

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, 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) Reserved for future use.

(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 . . . . . ☐

TIP: If you have self-employment income, see page 2.

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)

RATE TABLES FOR WAGE CHART

The rate tables listed below correspond to the letters in the Wage Chart on the front page. Use these to estimate the amount of withholding that will occur if you choose to use the wage chart. Compare this to your estimated income tax liability for your New Jersey Income Tax return to see if this is the correct amount of withholding that you should have.

RATE "A"

WEEKLY PAYROLL PERIOD (Allowance $19.20)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 385		1.5%	$ 0
$ 385	$ 673	$ 5.77	+ 2.0%	$ 385
$ 673	$ 769	$ 11.54	+ 3.9%	$ 673
$ 769	$ 1,442	$ 15.29	+ 6.1%	$ 769
$ 1,442	$ 9,615	$ 56.35	+ 7.0%	$ 1,442
$ 9,615	$ 96,154	$ 628.46	+ 9.9%	$ 9,615
$ 96,154		$ 9,195.77	+ 15.6%	$ 96,154

ANNUAL PAYROLL PERIOD (Allowance $1,000)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 20,000		1.5%	$ 0
$ 20,000	$ 35,000	$ 300.00	+ 2.0%	$ 20,000
$ 35,000	$ 40,000	$ 600.00	+ 3.9%	$ 35,000
$ 40,000	$ 75,000	$ 795.00	+ 6.1%	$ 40,000
$ 75,000	$ 500,000	$ 2,930.00	+ 7.0%	$ 75,000
$ 500,000	$ 5,000,000	$ 32,680.00	+ 9.9%	$ 500,000
$ 5,000,000		$ 478,180.00	+ 15.6%	$ 5,000,000

RATE "B"

WEEKLY PAYROLL PERIOD (Allowance $19.20)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 385		1.5%	$ 0
$ 385	$ 962	$ 5.77	+ 2.0%	$ 385
$ 962	$ 1,346	$ 17.31	+ 2.7%	$ 962
$ 1,346	$ 1,538	$ 27.69	+ 3.9%	$ 1,346
$ 1,538	$ 2,885	$ 35.19	+ 6.1%	$ 1,538
$ 2,885	$ 9,615	$ 117.31	+ 7.0%	$ 2,885
$ 9,615	$ 96,154	$ 588.46	+ 9.9%	$ 9,615
$ 96,154		$ 9,155.77	+ 15.6%	$ 96,154

ANNUAL PAYROLL PERIOD (Allowance $1,000)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 20,000		1.5%	$ 0
$ 20,000	$ 50,000	$ 300.00	+ 2.0%	$ 20,000
$ 50,000	$ 70,000	$ 900.00	+ 2.7%	$ 50,000
$ 70,000	$ 80,000	$ 1,440.00	+ 3.9%	$ 70,000
$ 80,000	$ 150,000	$ 1,830.00	+ 6.1%	$ 80,000
$ 150,000	$ 500,000	$ 6,100.00	+ 7.0%	$ 150,000
$ 500,000	$ 5,000,000	$ 30,600.00	+ 9.9%	$ 500,000
$ 5,000,000		$ 476,100.00	+ 15.6%	$ 5,000,000

RATE "C"

WEEKLY PAYROLL PERIOD (Allowance $19.20)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 385		1.5%	$ 0
$ 385	$ 769	$ 5.77	+ 2.3%	$ 385
$ 769	$ 962	$ 14.62	+ 2.8%	$ 769
$ 962	$ 1,154	$ 20.00	+ 3.5%	$ 962
$ 1,154	$ 2,885	$ 26.73	+ 5.6%	$ 1,154
$ 2,885	$ 9,615	$ 123.65	+ 6.6%	$ 2,885
$ 9,615	$ 96,154	$ 567.88	+ 9.9%	$ 9,615
$ 96,154		$ 9,135.19	+ 15.6%	$ 96,154

ANNUAL PAYROLL PERIOD (Allowance $1,000)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 20,000		1.5%	$ 0
$ 20,000	$ 40,000	$ 300.00	+ 2.3%	$ 20,000
$ 40,000	$ 50,000	$ 760.00	+ 2.8%	$ 40,000
$ 50,000	$ 60,000	$ 1,040	+ 3.5%	$ 50,000
$ 60,000	$ 150,000	$ 1,390.00	+ 5.6%	$ 60,000
$ 150,000	$ 500,000	$ 6,430.00	+ 6.6%	$ 150,000
$ 500,000	$ 5,000,000	$ 29,530.00	+ 9.9%	$ 500,000
$ 5,000,000		$ 475,030.00	+ 15.6%	$ 5,000,000

RATE "D"

WEEKLY PAYROLL PERIOD (Allowance $19.20)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 385		1.5%	$ 0
$ 385	$ 769	$ 5.77	+ 2.7%	$ 385
$ 769	$ 962	$ 16.15	+ 3.4%	$ 769
$ 962	$ 1,154	$ 22.69	+ 4.3%	$ 962
$ 1,154	$ 2,885	$ 30.96	+ 5.6%	$ 1,154
$ 2,885	$ 9,615	$ 127.88	+ 6.5%	$ 2,885
$ 9,615	$ 96,154	$ 565.38	+ 9.9%	$ 9,615
$ 96,154		$ 9,132.69	+ 15.6%	$ 96,154

ANNUAL PAYROLL PERIOD (Allowance $1,000)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 20,000		1.5%	$ 0
$ 20,000	$ 40,000	$ 300.00	+ 2.7%	$ 20,000
$ 40,000	$ 50,000	$ 840.00	+ 3.4%	$ 40,000
$ 50,000	$ 60,000	$ 1,180.00	+ 4.3%	$ 50,000
$ 60,000	$ 150,000	$ 1,610.00	+ 5.6%	$ 60,000
$ 150,000	$ 500,000	$ 6,650.00	+ 6.5%	$ 150,000
$ 500,000	$ 5,000,000	$ 29,400.00	+ 9.9%	$ 500,000
$ 5,000,000		$ 474,900.00	+ 15.6%	$ 5,000,000

RATE "E"

WEEKLY PAYROLL PERIOD (Allowance $19.20)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 385		1.5%	$ 0
$ 385	$ 673	$ 5.77	+ 2.0%	$ 385
$ 673	$ 1,923	$ 11.54	+ 5.8%	$ 673
$ 1,923	$ 9,615	$ 84.04	+ 6.5%	$ 1,923
$ 9,615	$ 96,154	$ 584.04	+ 9.9%	$ 9,615
$ 96,154		$ 9,151.35	+ 15.6%	$ 96,154

ANNUAL PAYROLL PERIOD (Allowance $1,000)

If the amount of taxable wages is: Over	But Not Over	The amount of income tax to be withheld is:		Of Excess Over
$ 0	$ 20,000		1.5%	$ 0
$ 20,000	$ 35,000	$ 300.00	+ 2.0%	$ 20,000
$ 35,000	$ 100,000	$ 600.00	+ 5.8%	$ 35,000
$ 100,000	$ 500,000	$ 4,370.00	+ 6.5%	$ 100,000
$ 500,000	$ 5,000,000	$ 30,370.00	+ 9.9%	$ 500,000
$ 5,000,000		$ 475,870.00	+ 15.6%	$ 5,000,000

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.

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 2022 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:
- $25,900 if you're married filing jointly or qualifying widow(er)
- $19,400 if you're head of household
- $12,950 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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT & PAY STUB VIA EMAIL

I hereby authorize the Township of Jackson to initiate by electronic means direct deposits (credit entries) of my net earnings to my account(s) in the entity named below ("Depository") and to initiate, if necessary, debit entries and adjustments for any credit entries in error. I authorize the Depository to accept and to credit and/or debit the amount of such entries to my account.

If you are using three accounts, please specify a dollar amount in the 1st two accounts. The balance of your net pay will automatically be deposited into the 3rd account.

1. Depository Name: _____ Location: _____

( ) Savings ( ) Checking Account Number: _____

Transit/ABA Routing #: _____

Specify Dollar Amount (if using more than one account) _____ or % _____

2. Depository Name: _____ Location: _____

( ) Savings ( ) Checking Account Number: _____

Transit/ABA Routing #: _____

Specify Dollar Amount (if using more than one account) _____ or % _____

3. Depository Name: _____ Location: _____

( ) Savings ( ) Checking Account Number: _____

Transit/ABA Routing #: _____

Specify Dollar Amount (if using more than one account) _____ or % _____

By entering my email address below, I hereby authorize the Township of Jackson to email an electronic version of my stub per pay period to said email address in lieu of paper copies.

Email Address: _____

This authorization is to remain in full force and effect until the Township of Jackson has received written notification from me of its termination in such time and in such manner as to afford the Township of Jackson and the Depository a reasonable opportunity to act on it and in no event shall a termination notice be effective with respect to entries processed by the Township of Jackson or the Depository prior to its receipt.

Employee Name: _____ SS # _____

Employee Signature: _____ Date: _____

Submit a voided blank personalized check (no deposit slips)
Attach Check Here