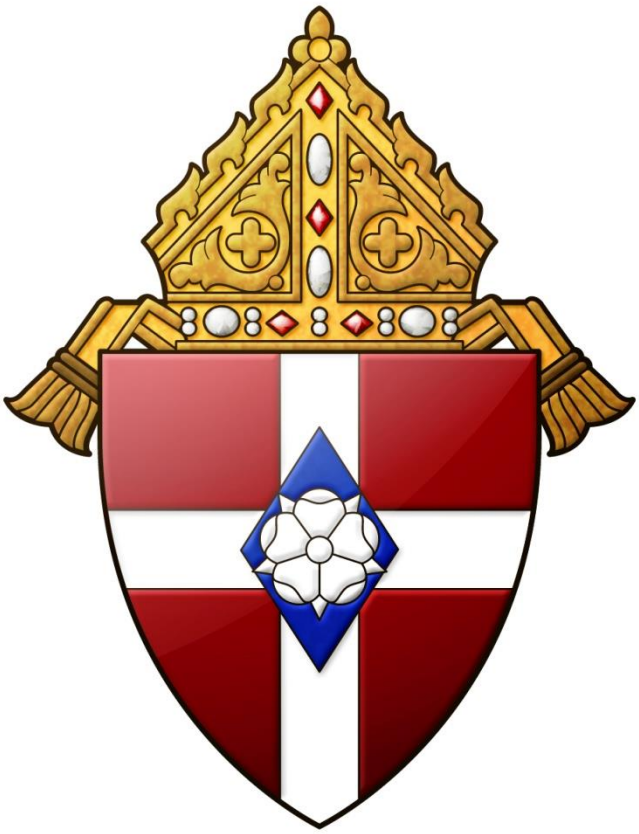
Employee Benefits Guide for Parish Administrators



Diocese of
Winona-Rochester

2907 Jeremiah Lane NW
Rochester, MN 55901
507-454-4643

Effective 7/1/24 – 6/30/25 – Refer to online documents to ensure current documents and forms.

DIOCESE OF WINONA-ROCHESTER

Employee Benefits Guide Overview for Administrators

This guide is an outline of the procedures and forms that need to be completed when hiring new employees, when employees are terminating, or when an employee is making changes in the Diocese of Winona-Rochester benefit programs. Enrollment, termination and changes for each benefit program are summarized separately and the corresponding forms links. This guide should be your directions for forms and information. Preference is for online forms to be used, however, forms may be found on the website at:

https://www.dowr.org/offices/human-resources/index.html

Upon hiring new employees and terminating employees, it is necessary to notify the Employee Benefits Coordinator at the Diocese of Winona-Rochester within 5 days of such event.

The following can be obtained by clicking on the links below:

- Form 001– for all new hires (benefit eligible or not), terminations of benefit-eligible employees, and names changes for all benefit-eligible employees.
- New Hire Checklist
- Termination Checklist

If you have any questions, please do not hesitate to contact the Diocese of Winona-Rochester Employee Benefits Coordinator at 507-858-1268.

The Benefits Manual is also on the diocesan website at:

DOW-R Employee Benefits Manual for Administrators
(https://www.dowr.org/offices/human-resources/benefits.html)

Please note: All documents can be accessed online by clicking on the links below or at https://www.dowr.org/offices/human-resources/index.html and are current, whereas your previously printed documents may not be current.

Table of Contents	Date	Chng	Form#
Employee Benefits Guide Overview	4/15/24	Y	
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Delta Dental Highlights and Coverage for Lay Employees and Clergy	1/1/2024	Y	
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Summary Plan Booklet - Delta Dental – Online only through www.DeltaDentalMN.org			
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403(b) Lay Employees Retirement Plan Participation and Form Directions	6/10/24	Y	
Enrollment Booklet – Online only or obtain from diocesan Benefit Office			
403(b) Lay Employees Retirement Plan Information for Terminating/Retiring Participants	6/10/24	Y	
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Information: FSA – Limited Purpose (used with an HSA) – Online only			
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Information: Accessing Flexible Spending Account Information Online – Online only	10/25/18		
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Revised 6/10/2024

DIOCESE OF WINONA-ROCHESTER EMPLOYEE BENEFITS SUMMARY

Eligibility: All Diocese of Winona-Rochester employee benefits are written as corporate plans and are available to be adopted by any parish, school, or other institution under the jurisdiction of the Bishop of Winona-Rochester. Persons working for these employers are eligible for diocesan benefits if they work at least 20 hours a week or work at least half-time during the academic year, regardless of job title. Employees hired on a temporary basis working 30 or more hours per week are eligible for health insurance on the first of the month following 60 days of continuous employment (call HR/Benefits for further explanation). In addition, the (403)b Lay Retirement and Flexible Benefits Account (FSA) Plans require employees to be age 21 or over to participate.

All benefits are subject to change. Please refer to plan documents for a complete explanation of coverage. 2/27/2023

Medical/Dental/Life/Accidental Death & Dismemberment/Long Term Disability Insurance Plans

The following policy is in effect in the Diocese of Winona-Rochester: That all eligible lay employees, employed by parishes and institutions in the Diocese of Winona-Rochester, be enrolled in the Diocese of Winona-Rochester group insurance plan.

A. Medical: Eligible employees have two deductible plans to choose from - $2,500 and $5,000. The plans pay for eligible medical expenses at a rate 80% after the applicable deductible is met. Each plan has an annual out-of-pocket maximum for the participant. The $5,000 deductible plan is Health Savings Plan Account (HSA) plan. The $2,500 deductible plan has a co-pay program for prescription drugs; the co-pay amount is determined by the Medica Formulary Drug listing and is not an eligible HSA plan. Coverage is available in either single or family plans. The plans are administered by Medica and take advantage of the Medica network of participating medical providers. The use of non-participating providers may result in a benefit reduction.

B. Dental: Eligible employees who enroll in the medical plan are also provided with a dental plan. The dental plan pays for eligible dental expenses, with a maximum annual benefit of $1,500. Preventative services are paid at 100%. Basic procedures are paid at a rate of 80% after a $50 annual deductible. Major procedures are paid at a rate of 50% after the same $50 deductible. There is also an orthodontia benefit for dependents ages 8-19 (if on family coverage). The orthodontia benefit is 50% of eligible charges with a lifetime maximum benefit of $1,000. The plan is administered by Delta Dental of Minnesota and takes advantage of the Delta PPO network of participating dental providers. The use of non-participating providers may result in a benefit reduction.

C. Life and Long-Term Disability (LTD): Each eligible employee is covered by a term life insurance policy equal to 1½ times the employee's annual salary, up to a maximum benefit of $50,000. Employees who become disabled will receive a monthly benefit equal to 60% of salary, after a 90-day waiting period. Life and LTD contracts are written by Unum and the premiums are paid by the employer.

D. Accidental Death and Dismemberment (AD&D) Life Insurance: In the event of an accidental death, the employee will receive an additional death benefit equal to the life benefit. AD&D insurance contracts are written by Mutual of Omaha and the premium is paid by the employer.

403 (b) Lay Retirement Plan

Type of Plan:	Tax Deferred 403(b) - Lincoln Alliance®
Eligibility:	Employees, age 21 or older, who are normally scheduled to work 20 or more hours per week. Participation is effective at date of hire for eligible employees.
Employer Discretionary Contribution:	3% of employee's wages.
Employee Elective Deferral:	Participant may contribute, via payroll deduction, from 1% to 100% of his/her wages up to the annual IRS limits (whole numbers only). Participant may change his/her elective deferral percentage effective the first day of any given month.
Employer Matching Contribution:	1% of employee's wages if the employee contributes 1%; 2% of employee's wages if the employee contributes 2%; 3% of the employee's wages if the employee contributes 3% or more; otherwise 0%.
Vesting - Employer Contributions:	20% vesting (ownership) per full year of eligible employment. Participant is 100% vested after 5 years.
Vesting - Employee Contributions:	Participant is always 100% vested in his/her elective deferral contributions.
Investments Options:	Participant directs all contributions to a variety of widely-recognized mutual funds. Participant also has the option to select a *LifeSpan*® asset allocation model, which provides allocation among the various investment options, based on a targeted retirement date. Participant may change investment options at any time.
Default Investment Election:	Participants who do NOT make individual investment elections for their contributions will automatically be invested in a LifeSpan® Target Date Model based on the participant's date of birth and the date closest to when the participant will reach the plan's normal retirement age of 65.
Withdrawal of Funds:	Participant may be eligible to withdraw money from the vested account balance when the following events occur: - Reach age 59½ - Upon retirement - Upon death - Upon total and permanent disability - A financial hardship, as defined by IRS guideline - No longer employed within the Diocese of Winona-Rochester Please note that distribution restrictions may apply to certain accounts under each of the above events. Taxes will be due upon distribution and if taken before age 59½, may be subject to an additional 10% federal tax penalty.
Loans:	Participant may borrow from his/her elective deferral account balance. Minimum loan amount is $1,000 and only one loan may be outstanding at a time. Loan must be repaid within 5 years, except loans used to purchase primary residence.
Fees:	The mutual funds in this program contain operating expenses just like all mutual funds.

Flexible Spending Account Medical and Dependent Care Benefit Plans (Administered by "WEX")

Purpose:	To allow employees to reduce their taxable income and to use that deferred amount to purchase qualified benefits. New employees have 30 days from their date of employment to enroll in the plan.
Qualified Benefits:	Family medical expenses up to maximum of $3,050 per plan year (calendar year) with a minimum of $150. Dependent care expenses up to maximum allowed by IRS per plan year with a minimum of $150.
Administration:	Total amount deferred for the plan year is deducted from employee's gross pay. The medical expense and dependent care portion is forwarded to the Diocese of Winona-Rochester to be held in a separate fund. When an employee has qualified expenses, the employee files a claim form with Further, the Flexible Benefits Plan third party administrator.
Employee Savings:	The amount of employee-deferred wages is not subject to state or federal income taxes or Social Security/Medicare taxes. The W-2 form issued to the employee will be total annual salary minus flex plan deferrals.
Employer Savings:	Because deferred amounts are not subject to the Social Security/Medicare tax, the employer also saves their share of the tax, which is currently 7.65%.
Social Security:	It should be noted that any amount deducted from wages in this plan are not subject to Social Security/Medicare tax, and may affect the employee's social security benefits upon retirement.
Unused Accounts:	Employees should be very conservative when they decide on their income deferrals for the plan year. Amounts not incurred for qualified expenses cannot be returned to the employee.
Fees:	There are no fees paid by the employees. The Diocese of Winona-Rochester charges an annual fee to each participating employer based on the cost to administer the plan.

Note: This document is a summary of the various employee benefit programs offered by the Diocese of Winona-Rochester. In the case of an inconsistency between this and the "Plan" document or other policy related document will take precedence.

Supplemental Life Insurance (Administered by Unum)

Coverage Amounts	
Employee	Up to 5 times salary in increments of $10,000. Up to a maximum of the lesser of 5x salary or $500,000.
Spouse	Up to 100% of employee amount in increments of $5,000. Not to exceed $500,000. Benefits will be paid to the employee.
Child(ren)	Up to 100% of employee coverage amount in increments of $2,000. Not to exceed $10,000 (up to age 26). The maximum death benefit for a child between the ages of live birth and 6 months is $1,000. Benefits will be paid to the employee. The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.
Increase in Coverage	Once you enroll, you are able to increase the coverage amount at annual enrollment or a qualifying event. You and your eligible dependents may purchase additional life coverage up to the guarantee issue amount without evidence of insurability. Coverage over the guarantee issue amount requires evidence of insurability.
Guarantee Issue	If you and your eligible dependents enroll within 30 days of your eligibility date, you may apply for any amount of life coverage up to $200,000 for yourself and any amount of coverage up to $25,000 for your spouse. Any life coverage over the guarantee issue amount is subject to evidence of insurability.
30 days of eligibility	You have 30 days to enroll you and your dependents in life insurance. Once the 30 days are up you will be able to enroll at yearly enrollment of January 1 or if you have a qualifying event, but you are required to furnish the evidence of insurability for the entire amount of coverage.

CONTACT INFORMATION

Blue Cross Blue Shield of Minnesota – Senior Gold Health Plan – Senior Priests/Retired Lay

Customer Service 888-878-0136
Main Website ..... www.bluecrossmn.com
Members online access to health plan..... www.bluecrossmnonline.com

Catholic Mutual/Ryan Christianson – Risk Manager

Phone 800-228-6108

Delta Dental of Minnesota – Dental Plan

Customer Service 800-553-9536
Main Website ..... www.DeltaDentalMN.org

Diocese of Winona-Rochester

Phone ..... 507-454-4643 Fax..507-454-8106
Main Website .....www.dowr.org
Mailing Address ..... 55 W. Sanborn P.O. Box 588 Winona, MN 55987

Staff

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Email..... kanderson@dowr.org
Phone 507-858-1241

Ann Ringlien ..... Accounting Assistant
Email..... aringlien@dowr.org
Phone 507-858-1247

Sandy Todd..... Controller
Email..... stodd@dowr.org
Phone 507-858-1245

Lincoln Alliance – 403(b) Lay Retirement and Multi-Fund

Customer Service 800-234-3500
Website ..... www.lfg.com

Medica – Health Plan – Lay, Active Priests, Seminary Students

Customer Service 877-347-0282
Main Website ..... www.medica.com
Members online access to health plan..... www.medica.com/login

WEX – Flexible Spending Accounts

Customer Service 866-451-3399
Members online access to flex plans..... www.wexinc.com/login/benefits-login/

DOW-R ⇨ BENEFIT ELIGIBLE ☐ YES ☐ NO -Complete form up to *

NOTICE OF

☐ **NEW EMPLOYEE HIRE OR INCREASE IN HOURS** ☐ **EMPLOYEE TERMINATION OR REDUCTION IN HOURS** ☐ **NAME CHANGE - (COMPLETE THROUGH CITY/STATE/ZIP)**

Please use new hire/termination form link found in Dropbox folder "HR Forms". If unable to use Dropbox, use this form.

Date: _____ Parish/School Name: _____

Employee Information (For Non-Benefit eligible employees – You do not have to complete the Qualifying Event information)

First Name: _____ **M.I.:** ____ **Last Name:** _____

Employee name must match your accounting/payroll & DOW-R No period in MI

Address: _____

City, State, Zip: _____ Home Phone # _____

Date of Birth: _____ Social Security #: _____

Start date or date hours increased: _____ Work Email address: _____

Note: start date is the date the employee started working, not the date they were hired.

Job Title: _____ If teaching, license #: _____

Will the new employee work with children or young adults: ☐ Yes ☐ No

Has the new employee worked at a Catholic school/church/institution within the Diocese of Winona-Rochester in the last 5 years: ☐ No ☐ Yes Where: _____

***Qualifying Event Information (check one)**

New hire or increase in hours:

☐ New Hire or ☐ Increase in hours
(from less than 20 to 20 or more per week

⇨ Transfer from DOW-R location: _____

⇨ Exempt employee ☐ No ☐ Yes (attach job description)

⇨FTE _____ or
Number of hours per week employee will work _____
Number of months per fiscal year _____

⇨ Annual salary _____

⇨ Date employee will receive first paycheck

Termination or decrease in hours (attach term/resign letter)

⇨ Effective date _____ ⇨ Last day worked _____

☐ Employee hired at different DOW-R location:
Hired at _____

☐ Termination of employment – involuntary ☐ Retirement

☐ Voluntary separation of employment, resignation or quit

☐ Reduction in hours less than benefit-eligible

⇨ Date of employee's final paycheck _____

⇨Date parish/school ends contribution to insurance _____

Parish/school representative **X** _____ _____
Signature Date

Place form in your Dropbox within 5 days of hire/termination – Do Not Email

or mail/fax to: Diocese of Winona-Rochester, Employee Benefits Coordinator, PO Box 588, Winona, MN 55987

Fax 507.454.8106 Questions? - Email: benefits@dowr.org or call 507-858-1268 ☐ **Uploaded to Dropbox**

Diocese of Winona-Rochester
NEW HIRE EMPLOYEE BENEFITS CHECKLIST*

EMPLOYEE'S NAME: _____

Please note, all links contain current forms. All links below will take you directly to the form or information.

Forms to be completed for new hires (links):

- Form 001 - completed by the hiring location, not by the employee
- Online benefit forms – use this link if you want your new hire benefit-eligible employee to complete the online benefit documents, which DOW-R Benefits receives and then uploads to Dropbox for your records. This link includes the applicable A-1 through E-1DOW-R benefit documents for your location. If you submit a new hire form for the employee and email them this link and if the employee does not complete the forms, DOW-R Benefits will request you to contact the employee.
- You will still need to give the employee information about their benefits.

Please note, tell the employee their "Employee's Location," which is the same location you used for their Form 001. Typically, this is the entity that issues your W-2, considered your main parish or school. If you work at a school that is not consolidated, your location may be your parish. Consolidated locations are Cotter, Loyola, Pacelli, and Rochester Catholic Schools. For instance, you may work at Holy Spirit School, but you are a Rochester Catholic School (RCS) employee. If you don't know your location, it is on the online new hire form you completed.

Benefit Documents – paper documents

- Form A-1 Link* or if waiving, Form A-2 Link*
- Form B-1 Link*
- Form C-2 Link*
- Form D-2 Link*
- Form E-1 Link*

Payroll Forms

- Form I-9 Link
- Form W-4 Link
- Form W-4MN Link
- Form MN New Hire Link
-

*upload to Dropbox; the rest of the forms are for you to process.

HIRE:

- Send completed form to Diocese of Winona-Rochester
  - ☐ Notice of New Employee Hire/Increase of Hours Form 001: Form 001 Link. **Preference is completion of form using the online link, which you can obtain through Dropbox;** by using this link, benefits receives your form and will upload acknowledgement back to you. If you use the printed format, you will need to upload the document to Dropbox.
    - Please note name format must match what you have in your accounting/payroll system, contains no titles (you can designate title in a non-name area). The format is full legal first and last name, along with the middle initial, no period. Please include middle initial.

HEALTH/DENTAL INSURANCE – if location is participating in benefit.

- Upload completed form to Diocese of Winona-Rochester
  - ☐ Health Insurance Enrollment Group Coverage Form A-1 Form A-1 Link
  - ☐ Waiver for Medical/Dental Group Coverage Form A-2 (used only for new hires or changes) Form A-2 Link
- Information to give to employee (you may print information or direct employee to DOW-R website)
  - ☐ Health Insurance Marketplace Coverage Option Link
  - ☐ Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Link
  - ☐ Medica Summary Comparing $2500/$5000 Deductibles Link

- ☐ Dental Insurance Highlights and Coverage Link

- If enrolling
  - ☐ Directions for Online Access to Medica and Delta Dental Link
    - Employees can print their own identification card replacements
    - Access to coverage information and vital plan information
    - Employee receives their "Summary Plan Booklet" by registering accessing their accounts online.

LIFE/LTD/AD&D – if location is participating in benefit.

- Send completed form to Diocese of Winona-Rochester
  - ☐ Insurance Enrollment For: Basic Group (Term) Life, Long Term Disability (LTD), Accidental Death and Dismemberment (AD&D) – Form B-1 Link
- Information to Give to Employee
  - ☐ Benefits at a Glance
    - Life Insurance Plan (Basic Life) Link
    - LTD Plan Link
    - AD&D 24-Hour Accident Insurance Link
- Direct employee to DOW-R benefit website Section B
  - ☐ Summary Plan Booklet - Basic Group Life Insurance Plan Link
  - ☐ Summary Plan Booklet – LTD Link
  - ☐ Summary Plan Booklet – AD&D Link

RETIREMENT – 403(b) Lay Employees Retirement Plan – if location is participating in plan.

- Send completed form to Diocese of Winona-Rochester
  - ☐ Salary Reduction Agreement Form C-2 - Form C-2 Link
- Information to Give to Employee
  - ☐ 403(b) Lay employees Retirement Plan Information Link
  - ☐ Lincoln Enrollment Booklet – Direct employee to DOW-R HR/Benefit website Section B or give employee booklet which you can obtain from the diocese Link

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FLEXIBLE BENEFITS – if location is participating in benefit.

- Send completed form to Diocese of Winona-Rochester
  - ☐ Flexible Spending Account Enrollment Form D-2 Form D-2 Link
- Information to give to employee (you may print information or direct employee to DOW-R website)
  - ☐ Medical Flexible Spending Account Guide Link
  - ☐ Limited Purpose Flexible Spending Account (used if employee also has an HSA) Link
  - ☐ Dependent Care Flexible Spending Account Handout Link
  - ☐ Contribution Limits and Changes Link
  - ☐ FSA Calculator (online only) Link
  - ☐ Accessing Flexible Spending Account Information Online Link
  - ☐ Accessing Flexible Spending Account Information Mobile Link
- If enrolling, direct employee to accessing their flexible spending account online to obtain further information.

SUPPLEMENTAL LIFE

- Send completed form(s) to Diocese of Winona-Rochester
  - ☐ Insurance Enrollment Form for Supplemental (Term) Life Form E-1 Form E-1 Link
  - ☐ **Complete only if** employee chose life coverage over the Guarantee Issue amount of $200,000 for self or $25,000 for spouse Evidence of Insurability (EOI) – contact benefits@dowr.org for online form information.
- Information to Give to Employee
  - ☐ Benefits at a Glance – (Supplemental) Life Insurance Plan Link
  - ☐ Supplemental Life - Term Life Insurance Coverage Highlights Link
  - ☐ "Beneficiary Guide for Term Life Insurance" flyer Link
  - ☐ "What Would Your Family Do Without Your Income" flyer Link
  - ☐ "Group term life insurance" flyer Link
- If enrolling, direct employee to DOW-R HR/Benefit website Section E
  - ☐ Summary Plan Booklet - Supplemental Life Insurance Link

PAYROLL FORMS (Forms current)

- Do not send completed form(s) to Diocese of Winona-Rochester
  - ☐ I-9 Employment Verification Form I-9 Link
    - Form I-9 Instructions Only Link
  - ☐ W-4 Federal Form W-4 Link
  - ☐ W-4MN – (Note: All employees who complete an IRS W-4 form must complete the W-4MN form) Form W-4MN Link
  - ☐ MN New Hire Report (Note: For all newly hired and re-hired employees) Form MN New Hire Link
    - Form MN New Hire Instructions Only Link
      - The link above will also take you to the electronic reporting directions

***This checklist is for parish/school/cemetery/institution only and does not need to be sent to the Diocese of Winona-Rochester.**

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.

Instructions for Form I-9, 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

Anti-Discrimination Notice: Employers must allow all employees to choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information entered in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or **Supplement B, Reverification and Rehire**. Employees do NOT need to prove their citizenship, immigration status, or national origin when establishing their employment authorization for Form I-9 or E-Verify. Requesting such proof or any specific document from employees based on their citizenship, immigration status, or national origin, may be illegal. Similarly, discriminating against employees in hiring, firing, recruitment, or referral for a fee, based on citizenship, immigration status, or national origin may be illegal. Employers should not reject acceptable documentation due to a future expiration date. For more information on how to avoid discrimination or how to report it, contact the Immigrant and Employee Rights Section in the Department of Justice's Civil Rights Division at www.justice.gov/ier.

Purpose of Form I-9

Employers and employees must complete their respective sections of Form I-9. The form is used to document verification of the identity and employment authorization of each new employee (both U.S. citizen and noncitizen) hired after November 6, 1986, to work in the United States. In the Commonwealth of the Northern Mariana Islands (CNMI), employers must complete Form I-9 to document the verification of the identity and employment authorization of each new employee (both U.S. citizen and noncitizen) hired after November 27, 2011.

Definitions

Employee: A person who performs labor or services in the United States for an employer in return for wages or other remuneration. The term "employee" does not include individuals who do not receive any form of remuneration (e.g., volunteers), independent contractors, or those engaged in certain casual domestic employment.

Employer: A person or entity, including an agent or anyone acting directly or indirectly in the interest thereof, who engages the services or labor of an employee to be performed in the United States for wages or other remuneration. This includes recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors.

Authorized Representative: Any person an employer designates to complete and sign Form I-9 on the employer's behalf. Employers are liable for any statutory and regulatory violations made in connection with the form or the verification process, including any violations committed by any individual designated to act on the employer's behalf.

Preparer and/or Translator: Any individual who helps the employee complete or translates **Section 1** for the employee.

General Instructions

Form I-9 consists of:

- **Section 1**: Employee Information and Attestation
- **Section 2**: Employer Review and Verification
- Lists of Acceptable Documents
- Supplement A, Preparer and/or Translator Certification for Section 1
- Supplement B, Reverification and Rehire (formerly Section 3)

EMPLOYEES

Employees must complete and sign **Section 1** of Form I-9 no later than the first day of employment (i.e., the date the employee begins performing labor or services in the United States in return for wages or other remuneration). Employees may complete **Section 1** before the first day of employment, but cannot complete the form before acceptance of an offer of employment.

EMPLOYERS

Employers in the United States, except Puerto Rico, must complete the English-language version of Form I-9. Only employers located in Puerto Rico may complete the Spanish-language version of Form I-9 instead of the English-language version. Any employer may use the Spanish-language form and instructions as a translation tool.

All employers must:

- Make the instructions for Form I-9 and Lists of Acceptable Documents available to the employee when completing the Form I-9 and when requesting that the employee present documentation to complete Supplement B, Reverification and Rehire. See page 5 for more information.
- Ensure that the employee completes **Section 1**.
- Complete **Section 2** within three business days after the employee's first day of employment. If you hire an individual for less than three business days, complete **Section 2** no later than the first day of employment.
- Complete Supplement B, Reverification and Rehire when applicable.
- Leave a field blank if it does not apply and allow employees to leave fields blank in **Section 1**, where appropriate.
- Retain completed forms. You are not required to retain or store the page(s) containing the Lists of Acceptable Documents or the instructions for Form I-9. Do not mail completed forms to U.S. Citizenship and Immigration Services (USCIS) or Immigration and Customs Enforcement (ICE).

Additional guidance about how to complete Form I-9 may be found in the **Handbook for Employers: Guidance for Completing Form I-9 (M-274) and on I-9 Central.**

Section 1: Employee Information and Attestation

Step 1: Employee completes Section 1 no later than the first day of employment.

- All employees must provide their current legal name, complete address, and date of birth. If other fields do not apply, leave them blank.
- When completing the name fields, enter your current legal name and any last names you previously used, including any hyphens or punctuation. If you only have one name, enter it in the Last Name field and then enter "Unknown" in the First Name field.
- Providing your 9-digit Social Security number in the Social Security number field is voluntary, unless your employer participates in E-Verify. See page 5 for instructions related to E-Verify. Do not enter an Individual Taxpayer Identification Number (ITIN) as your Social Security number.

Step 2: Attest to your citizenship or immigration status.

You must select one box to attest to your citizenship or immigration status.

1. **A citizen of the United States.**
2. **A noncitizen national of the United States:** An individual born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.
3. **A lawful permanent resident:** An individual who is not a U.S. citizen and who resides in the United States under legally recognized and lawfully recorded permanent residence as an immigrant.

   Conditional residents should select this status. Asylees and refugees should NOT select this status; they should instead select "A noncitizen authorized to work." If you select "lawful permanent resident," enter your 7- to 9-digit USCIS Number (A-Number) in the space provided.

4. **A noncitizen (other than Item Numbers 2. and 3. above) authorized to work:** An individual who has authorization to work but is not a U.S. citizen, noncitizen national, or lawful permanent resident.

   If you select this box, enter the date that your employment authorization expires, if any, in the space provided. In most cases, your employment authorization expiration date is found on the documentation evidencing your employment authorization. If your employment authorization documentation has been automatically extended by the issuing authority, enter the expiration date of the automatic extension in this space.

   - Refugees, asylees, and certain citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or Palau, and other noncitizens authorized to work whose employment authorization does not have an expiration date, should enter N/A in the Expiration Date field.

   Employees who select "a noncitizen authorized to work" must enter **one** of the following to complete **Section 1**:

   (1) USCIS Number/A-Number (7 to 9 digits);

   (2) Form I-94 Admission Number (11 digits); or

   (3) Foreign Passport Number and the Country of Issuance

   Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Step 3: Sign and enter the date you signed Section 1. Do NOT back-date this field.

Step 4: Preparer and/or translator completes a Preparer and/or Translator Certification, if applicable.

If a preparer and/or translator assists an employee in completing Section 1, that person must complete a Certification area on Supplement A, Preparer and/or Translator Certification for Section 1, located on Page 3 of Form I-9. There is no limit to the number of preparers and/or translators an employee may use. Each preparer and/or translator must complete and sign a separate Certification area. Employers must ensure that they retain any additional pages with the employee's completed Form I-9. If the employee does not use a preparer or translator, employers are not required to provide or retain Supplement A.

Step 5: Present Form I-9 Documentation

Within three business days after your first day of employment, you, the employee, must present to your employer original, acceptable, and unexpired documentation that establishes your identity and employment authorization. For example, if you begin employment on Monday, you must present documentation on or before the Thursday of that week. However, if you were hired to work for less than three business days, you must present documentation no later than the first day of employment.

Choose which documentation to present to your employer from the Lists of Acceptable Documents. An employer cannot specify which documentation you may present from the Lists of Acceptable Documents. You may present either: 1.) one selection from List A or 2.) a combination of one selection from List B and one selection from List C. In certain cases, you may also present an acceptable receipt for List A, B, or C documents. For more information on receipts, refer to the M-274.

- List A documentations show both identity and employment authorization. Some documentation must be presented together to be considered acceptable List A documentation. If you present acceptable List A documentation, you should not be asked to present List B and List C documentation.
- List B documentation shows identity only and List C documentation shows employment authorization only. If you present acceptable List B and List C documentation, you should not be asked to present List A documentation. Guidance is available in the M-274 if you are under the age of 18 or have a disability (special placement) and cannot provide List B documentation.

Your employer must physically examine the documentation you present to complete Form I-9, or examine them consistent with an alternative procedure authorized by the Secretary of DHS. If your documentation reasonably appears to be genuine and to relate to you, your employer must accept the documentation. If your documentation does not reasonably appear to be genuine or to relate to you, your employer must reject it and provide you with an opportunity to present other documentation. Your employer may choose to make copies of your documentation, but must return the original(s) to you. Your employer may not ask for documentation to verify the information you entered in **Section 1**.

Section 2: Employer Review and Verification

Before completing **Section 2**, you, the employer, should review **Section 1**. If you find any errors or missing information in **Section 1.**, the employee must correct the error, and then initial and date the correction.

You may designate an authorized representative to act on your behalf to complete **Section 2.**

You or your authorized representative must complete **Section 2** by physically examining evidence of the employee's identity and employment authorization within three business days after the employee's first day of employment. For example, if an employee begins employment on Monday, you must review the employee's documentation and complete **Section 2** on or before the Thursday of that week. However, if the individual will work for less than three business days, **Section 2** must be completed no later than the first day of employment.

Step 1: Enter information from the documentation the employee presents.

You, the employer or authorized representative, must either physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, the original, acceptable, and unexpired documentation the employee presents from the Lists of Acceptable Documents to complete the applicable document fields in **Section 2.** You cannot specify which documentation an employee may present from these Lists of Acceptable Documents. A document is acceptable if it reasonably appears to be genuine and to relate to the person presenting it. Photocopies, except for certified copies of birth certificates, are not acceptable for Form I-9. Employees must present one selection from List A or a combination of one selection from List B and one selection from List C.

You may use common abbreviations for states, document titles, or issuing authorities, such as: "DL" for driver's license, and "SSA" for Social Security Administration. Refer to the M-274 for abbreviation suggestions.

List A documentation shows both identity and employment authorization.

- Enter the required information from the List A documentation in the first set of document entry fields in the List A column. Some List A documentation consists of a combination of documents that must be presented together to be considered acceptable List A documentation. If the employee presents a combination of documents for List A, use the second and third sets of document entry fields in the List A column. Use the Additional Information space, as necessary, for additional documents. When entering document information in this space, ensure you record all available document information, such as the document title, issuing authority, document number and expiration date.
- If an employee presents acceptable List A documentation, do not ask the employee to present List B and List C documentation.

List B documentation shows identity only, and List C documentation shows employment authorization only.

- If an employee presents acceptable List B and List C documentation, enter the required information from the documentation under each corresponding column and do not ask the employee to present List A documentation.
- If an employee under the age of 18 or with disabilities (special placement) cannot provide List B documentation, see the M-274 for guidance.

In certain cases, the employee may present an acceptable receipt for List A, B, or C documentation. For more information on receipts, refer to the Lists of Acceptable Documents and the M-274.

Photocopies

- You may make photocopies of the documentation examined but must return the original documentation to the employee.
- You must retain any photocopies you make with Form I-9 in case of an inspection by DHS, the Department of Labor, or the Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section.

Step 2: Enter additional information, if necessary.

Use the Additional Information field to record any additional information required to complete **Section 2**, or any updates that are necessary once **Section 2** is complete. Initial and date each additional notation. See the M-274 for more information. Such notations include, but are not limited to:

- Those required by DHS, such as extensions of employment authorization or a document's expiration date.
- Replacement document information if a receipt was previously presented.
- Additional documentation that may be presented by certain nonimmigrant employees.

You may also enter optional information, such as termination dates, form retention dates, and E-Verify case numbers, if applicable.

Step 3: Select the box in the Additional Information area if you used an alternate procedure for document examination authorized by the Secretary of DHS.

You must select this box if you used an alternative procedure authorized by DHS to examine the documents. You may refer to the M-274 for guidance on implementing alternative procedures for document examination approved by the Secretary of DHS.

Step 4: Complete the employer certification.

Employers or their authorized representatives, if applicable, must complete all applicable fields in this area, and sign and date where indicated.

Reverification and Rehire

To reverify an employee's work authorization or document an employee's rehire, use Supplement B, Reverification and Rehire (formerly Section 3). Employers need only complete and retain the supplement page when employment authorization reverification is required. Employers may choose to document a rehire on the supplement as well. Enter the employee's name at the top of each supplement page you use. In the New Name field, record any change the employee reports at the time of reverification or rehire. Use a new section of the supplement for each instance of a reverification or rehire, sign and date that section when completed, and attach it to the employee's completed Form I-9. Use additional supplement pages as necessary. Use the Additional Information fields if the employee's documentation presented for reverification requires future updates.

Reverifications

When reverification is required, you must reverify the employee by the earlier of the employment authorization expiration date stated in Section 1 (if any), or the expiration date of the List A or List C employment authorization documentation recorded in Section 2. Employers should complete any subsequent reverifications, if required, by the expiration date of the List A or List C documentation entered during the employee's most recent reverification.

For reverification, employees must present acceptable documentation from either List A or List C showing their continuing authorization to work in the United States. You must allow employees to choose which acceptable documentation to present for reverification. Employees are not required to show the same type of document they presented previously. Enter the documentation information in the appropriate fields provided.

You should not reverify the employment authorization of U.S. citizens and noncitizen nationals, or lawful permanent residents (including conditional residents) who presented a Permanent Resident Card (Form I-551) or other employment authorization documentation that is not subject to reverification (such as an unrestricted Social Security card). Reverification does not apply to List B documentation. Reverification may not apply to certain noncitizens. See the M-274 for more information about when reverification may not be required.

Rehires

If you rehire an employee within three years from the date the employee's Form I-9 was first completed, you may complete the supplement and attach it to the employee's previously completed Form I-9. If the employee remains employment-authorized, as indicated on the previously completed Form I-9, record the date of rehire and any name changes. If the employee's employment authorization or List A or C documents have expired, you must reverify the employee as described above.

Alternatively, you may complete a new Form I-9 for rehired employees. You must complete a new Form I-9 for any employee you rehired more than three years after you originally completed a Form I-9 for that employee.

Employee and Employer Instructions Related E-Verify

E-Verify uses Form I-9 information to confirm employees' employment eligibility. For more information, go to www.e-verify.gov or contact us at www.e-verify.gov/contact-us.

For employees of employers who participate in E-Verify:

- You must provide your Social Security number in the Social Security number field in **Section 1.**
  - If you have applied for, but have not yet received, your Social Security number, you should leave the field blank until you receive the number. Update this field once you receive it, and initial and date the notation.
  - If you can present acceptable identity and employment authorization documentation to complete Form I-9, you may begin working while waiting to receive your Social Security number.
- Providing your email address and telephone number in **Section 1** will allow you to receive notifications associated with your E-Verify case.
- If you present a List B document to your employer, it must contain a photograph.

For E-Verify employers:

- Ensure employees enter their Social Security number in **Section 1.**
- You must only accept List B documentation that contains a photograph. This applies to individuals under the age of 18 and individuals with disabilities.
- You must retain photocopies of certain documentation.

What is the Filing Fee?

There is no fee for completing Form I-9. This form is not filed with USCIS or any other government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the **"DHS Privacy Notice"** below.

USCIS Forms and Information

Employers may photocopy or print blank Forms I-9. To ensure you are using the latest version of this form and corresponding instructions, visit the USCIS website at www.uscis.gov/i-9. You may order paper forms at www.uscis.gov/forms/forms-by-mail or by contacting the USCIS Contact Center at **1-800-375-5283** or **1-800-767-1833** (TTY).

For additional guidance about Form I-9, employers and employees should refer to the **Handbook for Employers: Guidance for Completing Form I-9 (M-274)** or USCIS' Form I-9 website at www.uscis.gov/i-9-central.

You can obtain information about Form I-9 by e-mailing USCIS at I-9Central@uscis.dhs.gov. Employers may call **1-888-464-4218** or **1-877-875-6028** (TTY). Employees may call the USCIS employee hotline at **1-888-897-7781** or **1-877-875-6028** (TTY).

Retaining Completed Forms I-9

An employer must retain Form I-9, including any supplement pages, on which the employee and employer (or authorized representative) entered data, as well as any photocopies made of the documentation the employee presented, for as long as the employee works for the employer. When employment ends, the employer must retain the individual's Form I-9 and all attachments for one year from the date employment ends, or three years after the first day of employment, whichever is later. In the case of recruiters or referrers for a fee (only applicable to those that are agricultural associations, agricultural employers, or farm labor contractors), the retention period is three years after the first day of employment.

Completed Forms I-9 and all accompanying documents should be stored in a safe and secure location. Employers should ensure that the information employees provide on Form I-9 is used only as stated in the DHS Privacy Notice below.

Form I-9 may be generated, signed, and retained electronically, in compliance with Department of Homeland Security regulations at 8 CFR section 274a.2. Employers creating, modifying, or storing Form I-9 electronically are encouraged to review these and any other relevant standards for electronic signature, and the indexing, security, and documentation of electronic Form I-9 data.

Penalties

Employers may be subject to penalties if Form I-9 is not properly completed or for employment discrimination occurring during the employment eligibility verification process. See 8 U.S.C. section 1324a and section 1324b, 8 CFR section 274a.10 and 28 CFR Part 44. Individuals may also be prosecuted for knowingly and willfully entering false information, or for presenting fraudulent documentation, to complete Form I-9.

Employees: By signing **Section 1** of this form, employees attest under penalty of perjury (28 U.S.C. section 1746) that the information they provided, along with the citizenship or immigration status they select, and all information and documentation they provide to their employer, is true and correct, and they are aware that they may face penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or using false documentation when completing this form. Further, falsely attesting to U.S. citizenship may subject employees to penalties or removal proceedings, and may adversely affect an employee's ability to seek future immigration benefits.

Employers: By signing **Sections 2** and **3**, as applicable, employers attest under penalty of perjury (28 U.S.C. section 1746) that they have physically examined the documentation presented by the employee, that the documentation reasonably appears to be genuine and to relate to the employee named, that to the best of their knowledge the employee is authorized to work in the United States, that the information they enter in **Section 2** is complete, true, and correct to the best of their knowledge, and that they are aware that they may face civil or criminal penalties provided by law and may be subject to criminal prosecution for knowingly and willfully making false statements or knowingly accepting false documentation when completing Form I-9.

DHS Privacy Notice

AUTHORITIES: The information requested on this form, and the associated documents, are collected under the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 U.S.C. 1324a).

PURPOSE: The primary purpose for providing the requested information on this form is for employers to verify the identity and employment authorization of their employees. Consistent with the requirements of the Immigration Reform and Control Act of 1986, employers use the Form I-9 to document the verification of the identity and employment authorization for new employees to prevent the unlawful hiring, or recruiting or referring for a fee, of individuals who are not authorized to work in the United States. This form is completed by both the employer and the employee and is ultimately retained by the employer.

DISCLOSURE: The information employees provide is voluntary. However, failure to provide the requested information, and acceptable documentation evidencing identity and authorization to work in the United States, may result in termination of employment. Failure of the employer to ensure proper completion of this form may result in the imposition of civil or criminal penalties against the employer. In addition, knowingly employing individuals who are not authorized to work in the United States may subject the employer to civil and/or criminal penalties.

ROUTINE USES: This information will be used by employers as a record of their basis for determining eligibility of an individual to work in the United States. The employer must retain this completed form and make it available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Department of Justice, Civil Rights Division, Immigrant and Employee Rights Section. DHS may also share this information, as appropriate, for law enforcement purposes or in the interest of national security.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 34 minutes per response, when completing the form manually, and 25 minutes per response when using a computer to aid in completion of the form, including the time for reviewing instructions and completing and retaining the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Office of Policy and Strategy, Regulatory Coordination Division, 5900 Capital Gateway Drive, Mail Stop Number 2140, Camp Springs, MD 20588-0009; OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number
Address		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, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . 3 $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . 4(a) $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . 4(b) $

(c) Extra withholding. Enter any additional tax you want withheld each pay period . . 4(c) $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

CAUTION *Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.*

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

1 **Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 . . . . . 1 $ _____

2 **Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a . . . . . 2a $ _____

b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b . . . . . 2b $ _____

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . 2c $ _____

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. . . . . 3 _____

4 **Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) . . . . . 4 $ _____

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $ _____

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . 2 $ _____

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" . . . . . 3 $ _____

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information . . . . 4 $ _____

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . 5 $ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

DEPARTMENT OF REVENUE

2024 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

* 2 4 2 4 6 1 *

Employees

Complete Form W-4MN so your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes. If no Form W-4MN is in effect, the number of withholding allowances claimed will be zero.

First Name and Initial	Last Name	Social Security Number

Permanent Address

City | State | ZIP Code

Marital Status *(Check one):*

- ☐ Single; Married, but legally separated; or Spouse is a nonresident alien
- ☐ Married
- ☐ Married, but withhold at higher Single rate

Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.

☐ Section 1 — Determining Minnesota Allowances

A Enter "1" if no one else can claim you as a dependent . . . . . **A** _____

B Enter "1" if any of the following apply: . . . . . **B** _____

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

C Enter "1" if you are married. Or choose to enter "0" if you are married and have either a working spouse or more than one job. *(Entering "0" may help you avoid having too little tax withheld.)* . **C** _____

D Enter the number of dependents (other than your spouse or yourself) you will claim on your tax return. . . . . **D** _____

E Enter "1" if you will use the filing status Head of Household *(see instructions)*. . . . . **E** _____

F Add steps A through E. If you plan to itemize deductions on your 2024 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** _____

1 Minnesota Allowances. Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet . . . . . **1** _____

2 Additional Minnesota withholding you want deducted for each pay period *(see instructions)* . . . . . **2** $_____

☐ Section 2 — Exemption From Minnesota Withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:

- I had no Minnesota income tax liability last year
- I received a refund of all Minnesota income tax withheld
- I expect to have no Minnesota income tax liability this year

☐ **C** All of these apply:

- My spouse is a military service member assigned to a military location in Minnesota
- My domicile (legal residence) is in another state
- I am in Minnesota solely to be with my spouse. My state of domicile is _____

☐ **D** I am an American Indian that resides and works on a reservation for which I am enrolled *(see instructions)*.

Enter the reservation name: _____

Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: _____

☐ **E** I am a member of the Minnesota National Guard or an active-duty U.S. military member and claim exempt from Minnesota withholding on my military pay

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay

I certify that all information provided in Section 1 ***OR*** *Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.*

Employee's Signature | Date | Daytime Phone Number

Employees: Give the completed form to your employer.

Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. (Incomplete forms are considered invalid.) We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer	Minnesota Tax ID Number	Federal Employer ID Number (FEIN)

Address | City | State | ZIP Code

DEPARTMENT OF REVENUE

Form W-4MN Instructions for Employees

Complete this form for your employer to calculate the amount of Minnesota income tax to be withheld from your pay.

When must I complete Form W-4MN?

Complete Form W-4MN if any of these apply:

- You begin employment
- You change your filing status
- You reasonably expect to change your filing status in the next calendar year
- Your personal or financial situation changes
- You claim exempt from Minnesota withholding (see Section 2 instructions for qualifications)

If you have not had sufficient Minnesota income tax withheld from your wages, we may assess penalty and interest when you file your state income tax return.

Note: Your employer may be required to submit a copy of your Form W-4MN to the Minnesota Department of Revenue. You may be subject to a $500 penalty if you provide a false Form W-4MN.

You must enter your Social Security Number for this Form W-4MN to be valid.

What if I have completed federal Form W-4?

If you completed a 2024 Form W-4, you must complete Form W-4MN to determine your Minnesota withholding allowances.

What if I am exempt from Minnesota withholding?

If you claim exempt from Minnesota withholding, complete only Section 2 of Form W-4MN and sign and date the form to validate it. If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year in which you claim an exemption from Minnesota withholding.

You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

What if I am a nonresident alien for U.S. income taxes?

If you are a nonresident alien, you are not allowed to claim exempt from withholding. You will check the single box for marital status regardless of your actual marital status and may enter one personal allowance on Step A of Section 1. Enter zero on steps B, C, and E of Section 1.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, enter the number of dependents on Step D.

Section 1 — Minnesota Allowances Worksheet

Complete Section 1 to find your allowances for Minnesota withholding tax. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

If you expect to owe more income tax for the year than will be withheld, you can claim fewer allowances or request additional Minnesota withholding from your wages. Enter the amount of additional Minnesota income tax you want withheld on line 2 of Section 1.

Nonwage Income

Consider making estimated payments if you have a large amount of "nonwage income." Nonwage income (other than tax-exempt income) includes interest, dividends, net rental income, unemployment compensation, gambling winnings, prizes and awards, hobby income, capital gains, royalties, and partnership income.

Two Earners or Multiple Jobs

If your spouse works or you have more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4MN. Usually, your withholding will be more accurate when all allowances are claimed on the Form W-4MN for the highest paying job and zero allowances are claimed on the others.

Head of Household Filing Status

You may claim Head of Household as your filing status if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependents. Enter "1" on Step E if you may claim Head of Household as your filing status on your tax return.

What if I itemize deductions on my Minnesota return or have other nonwage income?

Use the Itemized Deductions and Additional Income Worksheet to find your Minnesota withholding allowances. Complete Section 1 on page 1, then follow the steps in the worksheet on the next page to find additional allowances.

Continued

Itemized Deductions and Additional Income Worksheet

1 Enter an estimate of your 2024 Minnesota itemized deductions. For 2024, you may have to reduce your itemized deductions if your income is over $232,500 ($116,250 for Married Filing Separately). . . . . _____

2 Enter one of the following based on your filing status: . . . . . _____

a. $29,150 if Married Filing Jointly

b. $21,900 if Head of Household

c. $14,575 if Single or Married Filing Separately

3 Subtract step 2 from step 1. If zero or less, enter 0 . . . . . _____

4 Enter an estimate of your 2024 additional standard deduction (from page 11 of the Form M1 instructions) . . . . . _____

5 Add steps 3 and 4 . . . . . _____

6 Enter an estimate of your 2024 taxable nonwage income . . . . . _____

7 Subtract step 6 from step 5. If zero, enter 0. If less than zero, enter the amount in parentheses. . . . . _____

8 Divide the amount on step 7 by $5,050. If a negative amount, enter in parentheses. Do not include fractions . . . . . _____

9 Enter the number on step F of Section 1 on page 1 . . . . . _____

10 Add step 8 and 9 and enter the total here. If zero or less, enter 0. Enter this amount on line 1 of page 1. . . . . _____

Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from Minnesota withholding. You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

Box A

Check box A of Section 2 to claim exempt if all of these apply:

- You meet the requirements to be exempt from federal withholding
- You had no Minnesota income tax liability in the prior year and received a full refund of Minnesota tax withheld
- You expect to have no Minnesota income tax liability for the current year

Box B

Check box B of Section 2 if you are not claiming exempt from federal withholding, but meet the second and third requirements for box A.

Box C

Check box C in Section 2 to claim exempt if all of these apply:

- You are the spouse of a military member assigned to duty in Minnesota
- You and your spouse are domiciled in another state
- You are in Minnesota solely to be with your active duty military spouse member

Boxes D-F

If you receive income from the following sources, it is exempt from Minnesota withholding. Your employer will not withhold Minnesota tax from that income when you check the appropriate box in Section 2.

- **Box D:** You receive wages as a member of an American Indian tribe living and working on the reservation of which you are an enrolled member. Enter the name of your reservation and your Certificate of Degree of Indian or Alaskan Blood (CDIB) number/enrollment number. **Members of the Minnesota Chippewa Tribe** can exclude income regardless of which Minnesota Chippewa Tribe reservation you live and work on. This affects members of these tribes:
  - Mille Lacs
  - Nett Lake (Bois Forte)
  - Fond du Lac
  - Leech Lake
  - White Earth
  - Grand Portage
- **Box E:** You receive wages for Minnesota National Guard (MNG) pay or for active duty U.S. military pay. MNG and active duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if they are taxable federally. For more information, see Income Tax Fact Sheet 5, *Military Personnel*.
- **Box F:** You receive a military pension or other military retirement pay calculated under U.S. Code title 10, sections 1401 through 1414, 1447 through 1455, and 12733. You may claim exempt from Minnesota withholding on this income even if it is taxable federally.

Note: You may not want to claim exempt if you (or your spouse if filing a joint return) expect to have other forms of income subject to Minnesota tax and you want to avoid owing tax at the end of the year.

If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

Nonresident Alien

If you are a nonresident alien for federal tax purposes, do not complete Section 2. See IRS Publication 519, *U.S. Tax Guide for Aliens*.

Continued

Line 2 — Additional Minnesota Withholding

If you would like an additional amount of tax to be deducted per payment period, enter the amount on line 2. Do not enter a percentage of the payment you want to be deducted.

Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the IRS, other states that guarantee the same privacy, or by court order. Your name, address, and Social Security Number are required for identification. Information about your allowances is required to determine your correct tax. We ask for your phone number so we can call if we have a question.

Questions?

- Website: www.revenue.state.mn.us
- Email: withholding.tax@state.mn.us
- Phone: 651-282-9999 or 1-800-657-3594 (toll-free)

Employer instructions are on the next page.

Form W-4MN Employer Instructions

Form W-4MN Requirement

Federal Form W-4 will not determine withholding allowances used to determine the amount of Minnesota withholding. Employees completing a 2024 Form W-4 will need to complete 2024 Form W-4MN to determine the appropriate amount of Minnesota withholding.

Lock-In Letters

IRS Letter 2800C tells you when the IRS believes your employee may have filed an incorrect federal Form W-4. If you receive this letter, you must provide the Minnesota Department of Revenue with a copy of the employee's Form W-4MN. We will verify the number of allowances that the employee may claim for Minnesota purposes. Continue using the Form W-4MN you were using at the time you received Letter 2800C from the IRS, until we notify you to change the amount of allowances on the employee's Form W-4MN. If the employee has not completed a Form W-4MN, have them complete the form and use the allowances calculated on that form until notified by the department.

Use the amount on line 1 of page 1 for calculating the withholding tax for your employees.

When does an employee complete Form W-4MN?

Employees complete Form W-4MN no later than when they begin employment or when their personal or financial situation changes.

How should I determine Minnesota withholding for an employee that does not complete Form W-4MN?

If an employee does not complete Form W-4MN and they have a federal Form W-4 (from 2019 or prior years) on file, use the allowances on their federal Form W-4. Otherwise, withhold Minnesota tax as if the employee is single with zero withholding allowances.

What if my employee claims to be exempt from Minnesota withholding?

If your employee claims exempt from Minnesota withholding, they must complete Section 2 of Form W-4MN. They must provide you with a new Form W-4MN by February 15 of each year. If you are paying an employee for wages that are exempt from withholding, such as Medicaid Waiver Payments or wages to H-2A visa workers, do not send us Form W-4MN.

When do I need to submit copies of a Form W-4MN to the department?

You must send copies of Form W-4MN to us if any of these apply:

- The employee claims more than 10 Minnesota withholding allowances
- The employee checked box A or B under Section 2, and you reasonably expect the employee's wages to exceed $200 per week
- You believe the employee is not entitled to the number of allowances claimed

You do not need to submit Form W-4MN to us if the employee is asking to have additional Minnesota withholding deducted from their pay.

We may assess a $50 penalty for each Form W-4MN you do not file with us when required.

Mail Forms W-4MN to:

Minnesota Department of Revenue
Mail Station 6501
600 N. Robert St.
St. Paul, MN 55146-6501

What if my employee is a resident of a state that has a reciprocity agreement with Minnesota?

Your employee must complete Form MWR, Reciprocity Exemption/Affidavit of Residency if both of these apply:

- They are a resident of North Dakota or Michigan, and
- They do not want you to withhold Minnesota tax from their wages

Your employee must complete a Form MWR by February 28 of each year, or within 30 days after they begin working or change their permanent residence. See Withholding Fact Sheet 20, *Reciprocity - Employee Withholding*, for more information.

What is an invalid Form W-4MN?

A Form W-4MN is considered invalid if any of these apply:

- There is any unauthorized change or addition to the form, including any change to the language certifying the form is correct
- The employee indicates in any way the form is false by the date they provide you with the form
- The form is incomplete or lacks the necessary signatures
- Both Section 1 and Section 2 were completed
- The employer information is incomplete

What if I receive an invalid form?

Do not use the invalid form to calculate Minnesota income tax withholding. Have the employee complete and submit a new Form W-4MN. If the employee does not give you a valid form, and you have an earlier Form W-4MN from them, use the earlier form to calculate their withholding.

If a valid Form W-4MN is not completed by the employee, withhold taxes as if the employee is single and claiming zero withholding allowances.

What if my employee is a nonresident alien of the United States?

If the wages to this employee are subject to income tax withholding, you will use Table 1 and the procedure under **Withholding Adjustment for Nonresident Alien Employees** in IRS Publication 15-T to determine the correct Minnesota withholding tax. Do not use this procedure for nonresident alien students from India and business apprentices from India. Also do not use this procedure for certain nonresident aliens who are residents of South Korea. See IRS Notice 1392 for special instructions and withholding exceptions.

Diocese of Winona-Rochester

TERMINATING EMPLOYEE CHECKLIST*

EMPLOYEE'S NAME: _____

HIRE/TERM:

- Upload completed form to Diocese of Winona-Rochester within five days of termination
  - ☐ Notice of Employee Termination of Employment Form 001 – contact benefits@dowr.org for online form link.

- If there is a separation agreement, upload separation agreement to Dropbox within five days of termination in order for COBRA to be completed correctly
  - ☐ Separation agreement

IF THE EMPLOYEE HAS HAD ANY OR ALL OF THE FOLLOWING:

- Health/dental insurance
- Basic life insurance
- Flexible benefits (dependent care does not qualify for COBRA)
- Supplemental life insurance

- Give to Employee
  - ☐ Information for Terminating Employees Alerus COBRA
    - Alerus handles COBRA on behalf of the diocese

PENSION (For locations participating in DOW-R retirement)

- Give to Employee
  - ☐ 403(b) Pension Plan Information for Terminating/Retiring Participants

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***This checklist is for parish/school/cemetery/institution only and does not need to be sent to the Diocese of Winona-Rochester.**

If you receive any benefits including health, dental, life, medical flexible benefits, or supplemental life insurance from the Diocese of Winona-Rochester, you will receive information from:

ALERUS

COBRA

I'VE LOST MY BENEFIT COVERAGE. WHAT ARE MY OPTIONS FOR COVERAGE NOW?

This loss of coverage is a qualifying event that opens a special enrollment window with carriers. At this time

- A spouse/parent can add you to their policy (if applicable)
- You can look for coverage on the open market: https://www.healthcare.gov
- You can enroll in COBRA

*Please note: different options have different costs, and enrolling under one option may disqualify you from enrolling in the other option(s) for this qualifying event. Be sure to review your options carefully and select the option that works best for your situation.

WHAT IS COBRA?

COBRA is a collection of federal laws and regulations that allow you to continue coverage of certain benefits for yourself (and any covered dependents, if applicable) under your company's plan for a designated period of time after a qualifying loss of coverage. The full notice of your rights and responsibilities, eligible benefits, associated costs, and timeline to enroll will be mailed to you from our COBRA administrator (listed below). If you have any questions, you can reach Alerus toll-free at 800.761.1934 or locally at 952.253.1261, or by email at cobra@alerus.com.

Alerus Retirement and Benefits
7650 Edinborough Way, Suite 645
Edina, MN 55435

WHAT TRIGGERS COBRA?

COBRA is offered when a covered employee experiences an involuntary loss of coverage. This can happen through such events as a resignation, retirement, termination, layoff, or reduction in hours. Covered dependents may also be offered COBRA if they lose coverage under a covered employee through such events as divorce, ageing off a parent's plan, or death of the employee.

WHAT IF I WANT TO ENROLL UNDER COBRA?

You have 60 days from the latter of the last day of coverage or the date the letter was sent to make your elections. You will have 45 days from the date we receive your elections to bring your account current. **In order to reinstate coverage with the insurance carriers, we (Alerus) must receive your elections as well as your first month's premium payment.** Once we receive both pieces, we send reinstatements to the carriers. It typically takes carriers 5-7 business days to process these reinstatement requests and for coverage to be showing active again. Coverage will be reinstated back to your first day of COBRA such that there is no lapse in coverage.

WHAT IF I DON'T WANT TO ENROLL UNDER COBRA?

COBRA is opt-in only — if you don't want it, you don't need to do anything with your notice and you will not be enrolled or charged anything. Per federal regulations, Alerus is required to keep you informed of any changes that may occur (such as a plan renewal) during the election period (60 days) even if you don't want COBRA. If the election period closes and you have not elected, you will not receive any further letters.

Diocese of Winona-Rochester

403(b) Lay Employees Retirement Plan

Information for Terminating/Retiring Participants

What types of contributions are in my 403(b) account?

There are two sources of contributions that have been made to your diocesan 403(b) lay retirement plan:

1. ***Employee Contributions***: The contributions you personally made to the plan are 100% vested (owned by you).

2. ***Employer Contributions****:* The contributions made to your account by your employer are 20% vested (owned by you) per full year of covered employment. The vesting schedule of the Diocese of Winona-Rochester Plan is 20% per year, with full vesting after 5 years or upon reaching age 60, whichever occurs first.

What happens to my vested 403(b) account balance?

Terminated participants have the following options for their vested 403(b) account balance:

1. ***Distribution*** – You may request a distribution of funds from your vested account balance.
    a. ***Pre-Tax Contributions (Traditional):*** The distribution will be considered taxable income in the year of distribution and a 20% federal tax will be withheld from the distribution. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.
    b. ***After-Tax Contributions (Roth):*** The distribution will not be considered taxable income in the year of distribution if your account has been held for at least five years and you are at least age 59 ½. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.

2. ***Direct Rollover or Transfer*** – You may request a transfer of your vested balance to another qualified retirement plan or an individual IRA.

3. ***Maintain your account*** - Terminated participants with a vested balance of less than $5,000 will have their vested account balance automatically transferred to a Lincoln Small Account IRA if they do not initiate a distribution, direct rollover, or transfer. Terminated participants with a vested account balance of $5,000 or greater may choose to retain their vested balance in the plan for future distribution. Participants must begin to take a distribution from the plan at age 73, called Required Minimum Distribution (RMD).

Who do I contact and where can I obtain the necessary forms?

First determine which Lincoln retirement account(s) you have; you may have one account or two separate accounts depending on your individual situation. Although all accounts are through Lincoln, each type of account has different contact information and different forms to

complete for account distribution or transfer. Quarterly statements are provided to participants and you may also refer to those statements to determine which account(s) you have a balance in.

Please keep the following items in mind when contacting Lincoln regarding your account(s):

- Effective 3/1/2010, all employee and employer contributions to the 403(b) retirement plan have been invested in the **Lincoln Alliance Program®**
- Prior to 3/1/2010, all employee and employer contributions to the 403(b) retirement plan were invested in **Lincoln Multi-Fund® Annuity**. Participants with Multi-Fund® accounts were given the opportunity to complete contract exchange paperwork to transfer those assets to the Lincoln Alliance Program®.

Lincoln Contact Information

To obtain information on your account(s) and plan forms, please use the following:

Diocese of Winona-Rochester 403(b) Lay Retirement Plan Retirement Consultant:

Wayne Lanum, CRPC

Email: Wayne.Lanum@LFG.com

Phone: 614-601-3825 Office

Lincoln Alliance Program® (Effective April 1, 2018)

CUSTOMER SERVICE
1-800-234-3500
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

Lincoln Multi-Fund® Annuity

CUSTOMER SERVICE
1-800-454-6265
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

MAILING ADDRESS
The Lincoln National Life Insurance Company
Attention - Annuities Operations
PO Box 2340
Fort Wayne, IN 46801-2340

DIOCESE OF WINONA-ROCHESTER

HEALTH INSURANCE PLANS

Participation and Form Directions

Administered by Medica and Delta Dental

Eligible participants are those employees who work at least 20 hours a week or at least one-half academic load during the school year. Employees hired on a temporary basis working 30 or more hours per week are eligible for health (medical and dental) insurance on the first of the month following 60 days of continuous employment (call HR/Benefits for further explanation). Health insurance starts on the first of the month coincident with or following the date of hire. **New employees have 30 days from their initial date of employment/eligibility to enroll. When the 30 days are over, employees can sign up at yearly renewal on January 1 or upon a qualifying event for a special enrollment.**

Please note, social security numbers are required on the enrollment forms for 1095-C purposes.

NEW EMPLOYEE FORM REQUIRED TO ENROLL OR WAIVE COVERAGE:

Health Insurance Enrollment Link for Group Coverage (includes all benefit documents)

PURPOSE: To initiate medical and dental coverage by collecting required information.

a. If enrolling, employees should complete appropriate sections based on enrolling themselves and/or dependents or waiving coverage.
b. Upon enrollment, the employee should register online with both Medica and Delta Dental, where they can access their summary plan descriptions and other information.
c. When enrolling, the employee enrolls in both the medical and dental insurance, as a health insurance package. They may not choose one or the other.

Health Insurance Waive Link for Group Coverage (includes all benefit documents)

PURPOSE: To prove the employee was offered the medical/dental insurance and wishes to waive their right to this benefit. *This form is only used for new employees.*

If a new employee does not wish to participate in the medical/dental plan, they MUST complete this form.

FORM REQUIRED TO BE GIVEN TO ALL BENEFIT-ELIGIBLE EMPLOYEES:

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

PURPOSE: The U.S. Government requires the diocese to give a copy of CHIP notice to EACH employee who works 20 or more hours per week – regardless of whether the employee is enrolled in the health care plan.

No action is required.

FORM REQUIRED FOR CHANGES TO EXISTING EMPLOYEES:

Address Change – no form needs to be completed – location to notify diocese by email.

Canceling Coverage – A-1

PURPOSE: To cancel coverage for medical and dental insurance for all health insurance coverage, all dependent coverage, or specific dependent coverage.

a. Employee should complete sections A (make sure effective date is entered), B (stating why canceling coverage), D, and G.
b. Notify the employee once they cancel coverage, they will not be able to enroll in health insurance until open enrollment unless they have a qualifying event. See below for special enrollment period.

Name Change – Health Insurance Enrollment/Change/Waive Form A-1

PURPOSE: To change name with no coverage changed. This form must be completed within 30 days of change. The employee's signature is required.

a. Employee should complete sections A and G. Social security number and date of birth do not need to be entered.
b. Please write former name on the top of the form.

Special Enrollment Period Health/Dental Enrollment/Change/Waive Link

PURPOSE: A Special Enrollment Period, which requires a qualifying event is a period during which the employee and/or employee's family has a right to enroll or make changes to existing health coverage. Special Enrollment Period qualifying or triggering events are listed below. Note: The online form link above is used for special enrollment.

- Loss of minimum essential coverage (does not include loss due to failure to pay premiums or rescission)
    - Loss of eligibility for employer-sponsored coverage
    - Termination of employment or reduction of hours
    - Legal separation or divorce
    - Loss of dependent child status
    - Death of employee
    - Move outside HMO service area
    - Exceeding the plan's lifetime maximum
    - Employer bankruptcy
    - Employee becomes entitled to Medicare
    - Loss of minimum essential coverage
- Gaining or becoming a dependent due to marriage
- Gaining a dependent due to birth, adoption or placement for adoption,
- An individual gains or loses eligibility for Medicaid or MinnesotaCare (notice must be received within 60 days of the event).

a. Notice period is 30 days except for Medicaid/SCHIP events.
b. Employee completes appropriate sections. Documentation of the qualify event or special enrollment notice must be included with enrollment form and included in your employee file.

TERMINATING EMPLOYEES

Notice of Employee Termination of Employment Form 001

PURPOSE: It is *very important* to complete and return this form promptly to comply with all COBRA regulations and MN Continuation laws. The Diocese of Winona-Rochester contracts with a third-party administrator (Alerus) for COBRA administration on the health and life insurances. **Please complete the Notice of Employee Termination of Employment form** and return it to the Employee Benefits Coordinator in Winona **within five days of the employee's termination**. The COBRA third party administrator will contact the employee directly regarding their option to continue this health and dental coverage.

NOTE – Upload ALL FORMS to Dropbox for processing. Location to maintain original for their employee records.

GENERAL INFORMATION:

Medical/Dental Group Numbers:

	Health	Dental
$2,500 Deductible	43849	00918
$5,000 Deductible	43850	00918

Renewal:
Annual renewal is January 1, with open enrollment occurring prior to the annual renewal. Employees may sign up or change deductible amounts only during open enrollment unless the employee has a qualifying event.

Single Medical/Dental Coverage:
Single coverage is coverage for only the employee.

Family Medical/Dental Coverage:
Family coverage is coverage for the employee and each member of the family.

- Employees may keep their adult children on the health/dental plan through age 26. A month before the adult child turns 26, the employee should notify the diocese, so COBRA may be offered to the adult child.
- Employees enrolling in family insurance will receive their health insurance identification cards from Medica; every member in the family will receive their own ID card. Delta Dental will provide cards with the employee's name only.

Insurance Address/Phone Information:

- Medica
  401 Carlson Parkway Minnetonka, MN 55305 877-347-0282

- Delta Dental of Minnesota
  PO Box 9304 Minneapolis, MN 55415 877-268-3384

Medica Health Summary

	$2500 DEDUCTIBLE IN-NETWORK BENEFIT	$5000 DEDUCTIBLE IN-NETWORK BENEFIT
Annual Deductible	$2,500 per person; $5,000 per family (Combined for in-network & out-of-network services)	$5,000 per person ; $10,000 per family (Combined for in-network & out-of-network services)
Out of Pocket Maximum	$5,000 per person; $10,000 per family (Combined for in-network & out-of-network services)	$5,000 per person; $10,000 per family (Combined for in-network & out-of-network services)
Preventive Care	100% coverage	100% coverage
Convenience Care	After deductible is met: 20% co-insurance	After deductible is met: 0% co-insurance
Office Visit and Urgent Care	After deductible is met: 20% co-insurance	After deductible is met: 0% co-insurance
Hospitalization (In and out patient)	After deductible is met: 20% co-insurance	After deductible is met: 0% co-insurance
Prescription Drugs	Generic : 25% Preferred: 25%	After deductible is met: Generic : 0% co-insurance Preferred: 0% co-insurance Non-Preferred: 0% co-insurance
Emergency Room	After deductible is met: 20% co-insurance	After deductible is met: 25% co-insurance

DELTA DENTAL®

Delta Dental of Minnesota

Delta Dental PPO™ & Delta Dental Premier®

Diocese of Winona – Rochester

Client #000917 & 000918

Plan Benefit Highlights as of January 1, 2024			
Network(s)	**Delta Dental PPO™**	**Delta Dental Premier®**	**Non-Participating***
Calendar Year Plan Maximum Per person	**$1,500**		
Lifetime Ortho Maximum (Group #918 Only) *Per eligible covered Lay person's dependent child age 8 thru 18*	Lay participants only $1,000		
Deductible Per person / per family per calendar year *No deductible for diagnostic and preventive services or orthodontics*	$50 per person / $150 per family		
Eligible Dependents	Spouse and dependent children up to age 26		
Covered Services	**Dental Benefit Plan Coverage**		
Diagnostic & Preventive Services **Exams** – 2 per calendar year **Cleanings** – 2 per calendar year **X-rays:** • **Bitewings** - once per 12-months • **Full Mouth/Panoramic** – once per 36-month period **Fluoride treatments** – once per 12-month period for dependent children through age 18 **Sealants** – once per 2 years for permanent first and second molars for eligible dependent children through the age of 18 **Space Maintainers** – once per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth	100%	100%	100%
Basic Services Emergency treatment for relief of pain Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) teeth	80%	80%	80%
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	80%	80%	80%
Periodontics Surgical/Nonsurgical periodontics	80%	80%	80%
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	80%	80%	80%
Major Restorative Crowns and Crown repair Composite resin restorations (white fillings) on posterior (back) teeth	50%	50%	50%
Prosthetic Repairs and Adjustments Denture adjustments and repairs Bridge repairs	50%	50%	50%
Prosthetics Dentures (full and partial) Bridges	50%	50%	50%
Orthodontics Treatment for the prevention/ correction of malocclusion *Available for dependent children ages 8 through age 18*	50%	50%	50%

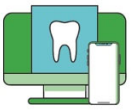
This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Dental Benefit Plan Summary.

*Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

DELTA DENTAL®

Make the Most of Your Benefits

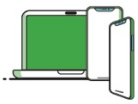
We're so glad you've joined us as your partner in oral health. 89 million members nationwide trust Delta Dental for superior dental expertise, service and savings. Below are resources to help you make the most of your dental benefits utilizing our digital tools, in-network dentists and best-in-class customer service.



Digital resources to manage your benefits

DeltaDentalMN.org

At Delta Dental of Minnesota, we're focused on providing effective digital resources for our members that align with our sustainability initiatives. The Member Portal and mobile app provides 24/7 access to tools for members to self-serve. The Member Portal and mobile app use a single sign on between the platforms, meaning only one username and password are needed for both!



Member Portal and mobile app features:

- Digital ID card
- Find a dentist
- Coverage details
- Claim details
- Cost estimator
- Digital Explanation of Benefits (EOB)
  Available exclusively on the Member Portal

Sign up for the Member Portal

Download the mobile app

Find a dentist

DeltaDentalMN.org/find-a-dentist

Seeking care from a Delta Dental in-network dentist will save you the most money because the dentist cannot charge you more than our allowable fee for services covered under your plan. Our Find a Dentist tool helps you find a dentist that fits your preferences and accessibility. You can also verify your current dentist's network participation.

Contact us

Phone: 1-800-448-3815
7a.m. - 7p.m., M-F CST

Our customer service team can assist members with the following topics:

Questions on coverage:

- Benefits and eligibility
- Claim status
- Explanation of Benefits (EOB) details

Digital access:

- Find a Dentist tool
- Website navigation
- Member Portal questions

The Power of Smile™

Learn more about how your oral health connects to your overall health at:

DeltaDentalMN.org

DELTA DENTAL®

Delta Dental of Minnesota

DDMN.8.5.23

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings on your premium that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit, that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact at this job?		
11. Phone number (if different from above)	12. Email address	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility –

IOWA – Medicaid and CHIP (Hawki)	MINNESOTA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website:http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
WISCONSIN – Medicaid and CHIP	**OTHER STATES**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	See publication online that lists other states: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Current Questions about Health and Dental Insurance

Currently I am enrolled in the $2,500 or $5,000 deductible plan. What do I have to do?

If you are going to remain on the same plan, you do not have to do anything during open enrollment.

On 1/1/2024, your plan will convert to a Medica $2,500 deductible plan or $5,000 deductible plan and your deductibles reset.

What diocesan plans offer "creditable" coverage in order to avoid paying a late enrollment penalty when I join a Medicare drug plan?

All diocesan health plans offer creditable coverage, including our high deductible plan of $5,000.

Health Savings Plan (HSA) -Eligible Health Plans

Only the DOW-R $5,000 deductible health plan is HSA-eligible. The IRS specifies "except for preventative care, the plan may not provide benefits for any year until the deductible for that year is met." The DOW-R $2,500 deductible plan is not HSA-eligible because it offers a prescription drug program with a 25% copay.

Employees enrolled in the $5,000 deductible plan may enroll in an HSA on their own. Employees can enroll in an HSA through a company of their choice.

If you participate in both an HSA and a medical flex spending account (FSA), your medical FSA must be limited to dental and vision expense reimbursement until your health plan deductible has been met. Contact "Further" to remove the limit when your deductible is met

As a reminder, if you are participating in any of the DOW-R health insurance plans, your deductibles accumulate based on the calendar year. Flexible Spending Accounts are also on a calendar year basis.
There may be more questions and answers later and will be updated on our website. In Section A, see "Current Questions about Health and Dental Insurance" at our website https://www.dowr.org/offices/human-resources/index.html.

Directions for Online Access to Medica and Delta Dental

MEDICA- ONLINE

Get all of your plan information on your member website, www.medica.com

To see your information, complete a **one-time registration** step. Once your Medica account is activated, you will have online access to:

- Claims – search, sort and check status
- Coverage – review a summary of your insurance coverage
- Spending – see how close you are to reaching your deductible and maximum
- Find a network doctor, hospital or clinic – get the care you need and see quality information, too
- Health and wellness – use a range of tools and resources
- Replacement member ID card – easy to see and order
- Contact customer service – secure message center

To register online, please click the link https://www.medica.com/login and then "Sign In." You will need to create an account and will need either your social security number of Medica ID number. Please select "I get insurance through an employer" and your plan is "Medica Choice Passport." After you follow the rest of the prompts, you will actually need to sign in again to access your account.

If you encounter errors, please contact Medica Customer Service at 1-877-347-0282; Mon-Fri 7 am – 8 pm CST

DELTA DENTAL - ONLINE

Access Delta Dental online at www.DeltaDentalMN.org

To see your information complete a **one-time registration** step. If you have previously registered, you do not have to register again. Once your DeltaDentalMN.org account is activated, you will have online access to:

- Coverage Summary – review your dental plan information
- Claims Inquiry – claim status, pre-estimates, service dates, procedure date, deductibles, etc.
- Find a dentist – Search for participating dentist, clinic, location, or specialized service
- Replacement member ID card – order duplicate or replacement card online
- Oral Health Resources – videos and informational flyers to improve your health by improving your oral health
- Dental Insurance 101 – general information

What are special enrollment periods?

A special enrollment period is outside open enrollment dates. During special enrollment, you can buy or make certain changes to your plan. Special enrollment is specific to you. It's triggered by what's known as a qualifying life event.

There are five types of qualifying life events:

Losing health coverage

One qualifying life event is the involuntary loss of health insurance. This can be due to job loss or a change in eligibility. It includes people who turn 26 and lose coverage under their parents' health plan. People who lose public insurance coverage are also included.

Household Changes

These include changes caused by marriage, divorce, birth, adoption, or death.

Change in address

If you had coverage and move, you may lose it and/or gain access to other plans. You'll also need to prove you had qualifying health coverage for one or more days during the 60 days before your move.

Change in income

If your income changes, you may be eligible for different plans. You also may have new access to an individual or public insurance program like Medicaid. The amount of financial assistance you can get also can change if your income does.

Other, less common changes

Less common changes that trigger special enrollment include becoming a U.S. citizen and leaving prison. Your state's health insurance marketplace will have a complete list. If you think you qualify for a special enrollment, here's what you need to know:

- Your special enrollment period will be open for 60 days from the date of your qualifying event.
- You must buy or make changes to your plan during that 60-day time period.

You'll need to submit proof of the qualifying event, along with completing an enrollment form.

DOW-R Dental Insurance

Medica

2024 GROUP ENROLLMENT/CHANGE/CANCELLATION/WAIVE FORM
Minnesota Healthcare Consortium and DOW-R Dental Insurance

Instructions:

IMPORTANT – PLEASE READ BEFORE COMPLETING

Please read and complete your enrollment/change/cancellation form thoroughly to ensure accurate processing.

- If **waiving Medical/Dental coverage**, complete Sections A and B.
- For new enrollees, please submit this completed enrollment/change/cancellation/waive form to your employer.
- If you are currently enrolled:
  - If **canceling Medical/Dental coverage**, please complete Sections A, D and G.
  - Only adding a dependent to your existing contract, please include your name in Section A and your dependent's information in all other sections.

Your Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption. You may have additional enrollment rights under applicable state law. For example, in Minnesota the notification period for dependent children is not limited to 30 days for newborns or children newly adopted or newly placed for adoption; however, Medica encourages you to request enrollment within 30 days.

If you or your dependents have lost coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP), you may be able to enroll yourself and/or your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends.

In addition, if you or your dependents become eligible for group health plan premium assistance provided by the Medicaid or SCHIP program, you may be able to enroll yourself and/or your dependents in this plan. You must request enrollment within 60 days after the date you or your dependents are determined to be eligible for premium assistance.

To obtain more information or request special enrollment, contact Medica Customer Service at 952-945-8000 or 1-800-952-3455 (TTY users, call 711).

Visit us at **Medica.com**.

DOW-R Dental Insurance

Medica

2024 Group Enrollment/Change/Cancellation Form

DOW-R Usage Loc#_____
Effective Date_____ Invoice CR D
Date to Medica_____ Month invoice _____
Date to DD _____ #----------

Please type or print clearly.

SECTION A - EMPLOYEE INFORMATION

SECTION

Effective Date: _____ ❑ **Name change only**			Have you been a Medica member before? ❑ Yes ❑ No	
First Name (Legal Name)[4] M.I.[4] Last Name[4]			Social Security Number[1]	Marital Status ❑ Single ❑ Married
Update	**Address (Must be a physical address, no P.O. Boxes)** [5]			
❑ Enroll ❑ Cancel ❑ Change ❑ Waive	Street			
	City	State	ZIP Code	County
Contact Information [6]				
Cellular/Home Telephone	Work Telephone	Email		
Gender ❑ Male ❑Female	Birth date (mm/dd/yy)	Date of hire (mm/dd/yy)		

Important:

1 Your Social Security number (SSN) is requested to report your coverage status to the federal government. The IRS requires Medica to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS, and/or Medica asking you to verify your SSN for 1095 tax form purposes.
2 For court-ordered or adopted dependent(s), legal documentation must be attached.
3 Medica does not administer student status verification, however, your employer may request this information for their records.
4 Please provide each applicant's name as stated on their Social Security card, if they have a Social Security card.
5 Please ensure your full address is filled out, so you can receive important mailings, including your Medica ID card and welcome kit.
6 Phone numbers are important for outreach for a variety of programs that help support our members.
7 If waiving coverage, complete only Section A and B.

SECTION B – WAIVER OF MEDICAL COVERAGE

This entire section must be completed if you or your dependents DO NOT want coverage.

1. I understand that I am eligible for coverage through my employer. I DO NOT want coverage for:

❑ Me and my dependents ❑ My spouse ❑ My dependents only

2. The reason I am declining coverage at this time is because I or my dependents have coverage provided through:

❑ Spouse's group plan ❑ Individual Policy ❑ South Dakota Risk Pool (dates of coverage):
❑ Medicare ❑ Group Coverage Continuation (COBRA) ❑ CHAND (dates of coverage):
❑ MinnesotaCare ❑ Medical Assistance ❑ Other:

Employee Signature: **X**	Date Signed:

Only sign if you are waiving coverage

DOW-R Dental Insurance

Medica

SECTION C – PRODUCT SELECTION and EFFECTIVE DATE (needed if not during open enrollment)

I understand that I am eligible for coverage through my employer. Check coverage below:

❑ Me (Single) ❑ $2,500 deductible

❑ Me and my dependents (Family) ❑ $5,000 deductible

2. Effective date of coverage if not during open enrollment: _____

3. Special Enrollment

❑ If enrolled because of special enrollment, submit documentation of qualifying event.

❑ List qualifying event: _____ Date of qualifying event: _____

SECTION D - MEMBER INFORMATION

	Check appropriate box	List all members to be covered/canceled/changed. Write name as it is stated on their social security card. First name[4] M.I.[4] Last name[4]	Gender	Birth Date (mm/dd/ yy)	Relationship[2]	Dependent's SSN[1]
1	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
2	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
3	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
4	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			
5	❑ Enroll ❑ Cancel ❑ Change		❑ M ❑ F			

If more than 4 dependents, complete a second page 3 Section D for them.

SECTION E – COORDINATION OF BENEFITS

Failure to complete this section may result in a delay in the processing of your claims.

1. While you are covered under this policy, will you or any family members covered under this plan have other health insurance or Medical coverage? ❑ Yes ❑ No **Note:** if your other policy ends at the start of this policy, do not complete.

If "Yes," you must fully complete the following section. Starting with the employee, list each family member applying for coverage and include information for all previous coverage in effect. If your coverage is still in effect, please write "current" or "present" in the end date field. Use extra paper as necessary.

Date of Coverage	Name of Insurance Company	Names of all members covered
Start: End:		
Start: End:		
Start: End:		

DOW-R Dental Insurance

Medica

SECTION F – MEDICARE INFORMATION

1. Are you, your spouse, or any of your dependents covered by Medicare? ❑ Yes ❑ No

   If "yes" please attach a copy of each Medicare ID card and complete the following:

Employee Medicare Information	**Spouse/Dependent Medicare Information**
Name:	**Name:**
Part A: ❑ Enrolled (Effective Date:_____/_____/_____)	**Part A:** ❑ Enrolled (Effective Date:_____/_____/_____)
Part B: ❑ Enrolled (Effective Date:_____/_____/_____)	**Part B:** ❑ Enrolled (Effective Date:_____/_____/_____)
Part D: ❑ Enrolled (Effective Date:_____/_____/_____)	**Part D:** ❑ Enrolled (Effective Date:_____/_____/_____)
Reason for Medicare eligibility:	**Reason for Medicare eligibility:**
❑ Over age 65 ❑ Kidney disease ❑ Disabled ❑ Disabled but actively at work	❑ Over age 65 ❑ Kidney disease ❑ Disabled ❑ Disabled but actively at work

SECTION

SECTION G – EMPLOYEE AUTHORIZATION & REPRESENTATION

Read this section, date and sign the form.

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any hospital, clinic, institution, physician, insurance company, employer or other person to give Medica/Delta Dental/Delta Dental or any of its designees any and all records or information pertaining to Medica/Delta Dental history or services rendered to Us. I understand that this information will be used for underwriting, risk rating, enrollment or eligibility for benefits.I understand that in certain circumstances Medica/Delta Dental may disclose the information collected to third parties without authorization and that the individuals enrolled on or added to this form have the right to see and correct their personal information in accordance with applicable law. I understand that I have the right to review Medica/Delta Dental's Privacy Notice before signing this form and to request a copy at any time. I authorize on behalf of Us the use of a Social Security Number for the purpose of identification. The information provided on this form is accurate and complete, to the best of my knowledge and/or belief. I understand and agree that any omissions or incorrect statements knowingly made by Us on this form may invalidate my or my dependent's coverage. I understand that I may revoke this authorization by notifying Medica/Delta Dental in writing.

If I revoke the authorization, it will not affect any actions already taken by Medica/Delta Dental prior to Medica/Delta Dental's receipt of the revocation. If I refuse to sign this authorization, it will affect my dependents' and my eligibility and enrollment for benefits. I understand that I may request a copy of this completed authorization form. Information used or disclosed pursuant to this authorization will remain subject to Medica/Delta Dental's privacy standards.

For North Dakota and South Dakota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental to obtain information about Us for 24 months from the date of signature.

For Minnesota residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental to obtain information about Us from the date of signature until termination of our coverage.

This authorization does not extend to a release concerning the performance of, or results of, a test to determine the presence of the HIV antibody or other bloodborne pathogen* performed on (1) a criminal offender or crime victim as a result of a crime that was reported to the police; (2) a patient who received the services of emergency Medica/Delta Dental services personnel* at a hospital or Medica/Delta Dental care facility; or (3) emergency Medica/Delta Dental services personnel who were tested as a result of performing emergency Medica/Delta Dental services.

For Wisconsin residents: For purposes of facilitating enrollment, unless revoked, this authorization permits Medica/Delta Dental to obtain information about Us for 30 months from the date of signature.

I understand that providing false information or omission of relevant information in this form may result in the denial of claims or cancellation or retroactive termination of coverage.

Employee Signature: X_____ Date Signed: _____

DOW-R Dental Insurance

Medica

2024 GROUP WAIVE FORM
Minnesota Healthcare Consortium and DOW-R Dental Insurance

Instructions:

IMPORTANT – PLEASE READ BEFORE COMPLETING

Please read and complete your enrollment/change/cancellation form thoroughly to ensure accurate processing.

- If **waiving Medical/Dental coverage**, complete Sections A and B.

Your Special Enrollment Rights Under HIPAA

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, adoption, or placement for adoption. You may have additional enrollment rights under applicable state law. For example, in Minnesota the notification period for dependent children is not limited to 30 days for newborns or children newly adopted or newly placed for adoption; however, Medica encourages you to request enrollment within 30 days.

If you or your dependents have lost coverage under Medicaid or a State Children's Health Insurance Plan (SCHIP), you may be able to enroll yourself and/or your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends.

In addition, if you or your dependents become eligible for group health plan premium assistance provided by the Medicaid or SCHIP program, you may be able to enroll yourself and/or your dependents in this plan. You must request enrollment within 60 days after the date you or your dependents are determined to be eligible for premium assistance.

To obtain more information or request special enrollment, contact Medica Customer Service at 952-945-8000 or1-800-952-3455 (TTY users, call 711).

Visit us at **Medica.com**.

DOW-R Dental Insurance

Medica

2024 Health Insurance Waive Form

DOW-R Usage Loc#_____
Effective Date_____ Invoice CR D
Date to Medica_____ Month invoice _____
Date to DD _____ #----------

Please type or print clearly.

SECTION A - EMPLOYEE INFORMATION

SECTION

Effective Date: _____				
First Name (Legal Name)[4]	M.I.[4]	Last Name[4]	Social Security Number[1]	Marital Status ❑ Single ❑ Married
Update	**Address (Must be a physical address, no P.O. Boxes) [5]**			
❑ Waive	Street			
	City	State	ZIP Code	
Contact Information [6]				
Cellular/Home Telephone	Work Telephone	Email		
Gender ❑ Male ❑Female	Birth date (mm/dd/yy)	Date of hire (mm/dd/yy)		

Important:

1 Your Social Security number (SSN) is requested to report your coverage status to the federal government. The IRS requires Medica to report this information. If you choose not to provide your SSN, you will likely be contacted by the IRS, and/or Medica asking you to verify your SSN for 1095 tax form purposes.
2 Please provide each applicant's name as stated on their Social Security card, if they have a Social Security card.
3 Please ensure your full address is filled out, so you can receive important mailings, including your Medica ID card and welcome kit.

SECTION B – WAIVER OF MEDICAL COVERAGE

This entire section must be completed if you or your dependents DO NOT want coverage.

1. I understand that I am eligible for coverage through my employer. I DO NOT want coverage for:

❑ Me and my dependents ❑ My spouse ❑ My dependents only

2. The reason I am declining coverage at this time is because I or my dependents have coverage provided through:

❑ Spouse's group plan ❑ Individual Policy ❑ South Dakota Risk Pool (dates of coverage):
❑ Medicare ❑ Group Coverage Continuation (COBRA) ❑ CHAND (dates of coverage):
❑ MinnesotaCare ❑ Medical Assistance ❑ Other:

Employee Signature: **X**	Date Signed:

Only sign if you are waiving coverage

DIOCESE OF WINONA-ROCHESTER

TERM LIFE INSURANCE and

LONG TERM DISABILITY (LTD) INSURANCE

Participation and Form Directions

Administered by Unum Provident

Eligible employees are those who work at least 20 hours a week or at least one-half academic load during the plan year. Temporary employees are not eligible. All eligible employees **must** be enrolled in the Life and LTD insurance. The premium is paid 100% by the employer. Employees are insured on the 1st of the month coincident with or following the date of hire.

FORM REQUIRED TO ENROLL AN EMPLOYEE:

1. Group Enrollment Form B-1

PURPOSE: To provide information to participate in the life and disability plans.

Please enter the name of your parish/school/institution in "Division," the employee's wage listed in "Salary," and also fill in the date of hire. The employee should complete the remaining boxes on the top of the form, list beneficiary information, and sign/date at the bottom. The employee's life benefit will be 1.5 times their annualized wage with a maximum benefit of $50,000.

2. Summaries

Each employee should be given the "Benefits at a Glance" handouts for the Life and LTD Plans (in Life/LTD/AD&D tab). Detailed Summary Plan Booklets that outline the Life and LTD benefits are available on the diocesan website at https://www.dowr.org/offices/human-resources/index.html in the Human Resources department.

FORMS REQUIRED FOR CHANGES TO EXISTING EMPLOYEES:

1. Group Enrollment Form B-1

PURPOSE: To change designated person(s) to receive benefits upon death of policy holder or to change employee's name.

Employee should complete a new Group Enrollment Form (B-1). Forms should be returned to the Diocese of Winona-Rochester Benefits.

2. Salary Changes

Upload any changes in employee annual salary as needed and at least annually to the Diocese of Winona-Rochester Benefits.

FORM REQUIRED TO FILE LIFE AND LTD CLAIMS:

Claim for Life Insurance Benefits or LTD Benefits

The employer should contact the diocese and the appropriate claim for benefits form will be provided.

TERMINATING EMPLOYEES:

PURPOSE: The Diocese of Winona-Rochester's third party vendor (Alerus) informs employees of their rights pertaining to the term life policy and to confirm their decision to elect continued coverage or terminate coverage. This only applies to the life insurance. LTD is not continued and will end when the employee's employment terminates.

DIOCESE OF WINONA-ROCHESTER

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Participation and Form Directions

Administered by Mutual of Omaha

Eligible employees are those who work at least 20 hours a week or at least one-half academic load during the plan year. Temporary employees are not eligible. All eligible employees **must** be enrolled in AD&D insurance. The premium is paid 100% by the employer. Employees are insured on the 1st of the month coincident with or following the date of hire.

FORMS REQUIRED TO ENROLL AN EMPLOYEE:

1. **Beneficiary Form B-1**

   PURPOSE: To designate person(s) to receive benefits upon death of policy holder.

2. **Summary**

   Each employee is to be given a copy of the 24-Hour Accident Insurance Summary that describes the benefits of the AD&D insurance.

FORMS REQUIRED TO MAKE CHANGES TO EXISTING EMPLOYEES:

1. **Beneficiary Form B-1**

   Employee should complete a new Beneficiary Form (B-2) for changes in beneficiaries or a name change.

2. **Salary Changes**

   Upload any changes in employee annual salary as needed and at least annually to the Diocese of Winona-Rochester Benefits.

FORM REQUIRED TO FILE AD&D CLAIMS:

Claim for AD&D Benefit

The employer should contact the diocese and the appropriate claim for benefits form will be provided.

FORMS REQUIRED FOR TERMINATING EMPLOYEES:

No form is required. The AD&D stops when the employee's employment terminates.

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN EFFECTIVE DATE: September 1, 2003

IDENTIFICATION NUMBER: 551767 035

ELIGIBLE GROUP(S):

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group before November 1, 2016: None

For employees entering an eligible group on or after November 1, 2016: First of the month coincident with or next following the date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

REHIRE:

If your employment ends and you are rehired within 1 year, your previous work while in an eligible group will apply toward the waiting period. All other Summary of Benefits' provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

Premium Waiver: 90 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

1.5 x annual earnings

All amounts are rounded to the next higher multiple of $1,000, if not already an exact multiple thereof.

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$50,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section. The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

BENEFITS AT A GLANCE

LONG TERM DISABILITY PLAN

This long term disability plan provides financial protection for you by paying a portion of your income while you are disabled. The amount you receive is based on the amount you earned before your disability began. In some cases, you can receive disability payments even if you work while you are disabled.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: September 1, 2003

IDENTIFICATION NUMBER: 551767 034

ELIGIBLE GROUP(S):

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group before November 1, 2016: None

For employees entering an eligible group on or after November 1, 2016: First of the month coincident with or next following the date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

REHIRE:

If your employment ends and you are rehired within 12 months, your previous work while in an eligible group will apply toward the waiting period. All other policy provisions apply.

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

ELIMINATION PERIOD:

90 days

Benefits begin the day after the elimination period is completed.

MONTHLY BENEFIT:

60% of monthly earnings to a maximum benefit of $5,000 per month.

Your payment may be reduced by deductible sources of income and disability earnings. Some disabilities may not be covered or may have limited coverage under this plan.

MAXIMUM PERIOD OF PAYMENT:

Age at Disability	Maximum Period of Payment
Less than Age 62	To Social Security Normal Retirement Age
Age 62	60 months
Age 63	48 months
Age 64	42 months

Age 65	36 months
Age 66	30 months
Age 67	24 months
Age 68	18 months
Age 69 or older	12 months

Year of Birth	Social Security Normal Retirement Age
1937 or before	65 years
1938	65 years 2 months
1939	65 years 4 months
1940	65 years 6 months
1941	65 years 8 months
1942	65 years 10 months
1943-1954	66 years
1955	66 years 2 months
1956	66 years 4 months
1957	66 years 6 months
1958	66 years 8 months
1959	66 years 10 months
1960 and after	67 years

No premium payments are required for your coverage while you are receiving payments under this plan.

REHABILITATION AND RETURN TO WORK ASSISTANCE BENEFIT:

10% of your gross disability payment to a maximum benefit of $1,000 per month.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are participating in the Rehabilitation and Return to Work Assistance program; and
- you are not able to find employment.

DEPENDENT CARE EXPENSE BENEFIT:

While you are participating in Unum's Rehabilitation and Return to Work Assistance program, you may receive payments to cover certain dependent care expenses limited to the following amounts:

Dependent Care Expense Benefit Amount: $350 per month, per dependent

Dependent Care Expense Maximum Benefit Amount: $1,000 per month for all eligible dependent care expenses combined

TOTAL BENEFIT CAP:

The total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 100% of your monthly earnings. However, if you are participating in Unum's Rehabilitation and Return to Work Assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under this plan) will not exceed 110% of your monthly earnings.

OTHER FEATURES:

Minimum Benefit

Pre-Existing: 3/12

Survivor Benefit

Work Life Assistance Program

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

The plan includes enrollment, risk management and other support services related to your Employer's Benefit Program.

Benefits At A Glance - AD&D

Mutual of Omaha Insurance Company

Mutual of Omaha

DESCRIPTION OF COVERAGE FOR

Diocese of Winona-Rochester

24-HOUR ACCIDENT INSURANCE

ELIGIBILITY

All full-time and part-time employees of the Policyholder in active employment in the United States who work at least 20 hours per week or are contracted for at least one half academic load.

EFFECTIVE DATE

Each eligible person becomes an Insured on the later of: (a) the policy effective date or (b) the 1st of the month coincident with or following the date of hire.

COVERAGE

This plan offers protection on a worldwide basis, 24 hours a day, 365 days a year against any covered accident in the course of business or pleasure, including accidents on or off the job, in or away from the home, commuting, traveling by train, airplane, automobile or other private and public conveyances. It also covers accidents while riding as a passenger in any licensed civilian aircraft or in any aircraft operated by the Military Airlift Command. The benefits provided are payable in addition to any other insurance which may be in effect at the time of the accident.

BENEFIT AMOUNT

The amount of insurance you are eligible for is called the Principal Sum. Your Principal Sum amount is 1.5 times your Annual Salary, rounded to the next higher not to exceed a maximum of $50,000.00

BENEFITS

Accidental Death and Specific Loss Benefits
Benefits are payable when covered injuries result in loss within 365 days after the date of the accident. The Loss Period requirement is waived if the Insured is in a Coma or is being kept alive by artificial support system. Certain losses are payable at 100% of the Principal Sum and other losses are payable at a lesser percentage, as follows:

Loss of:	
Life	Principal Sum
Two Members	Principal Sum
One Member	½ Principal Sum
Thumb and Index Finger of the Same Hand	¼ Principal Sum

If you suffer multiple losses due to the same accident, only the largest benefit amount to which you are entitled – is payable. The benefit for loss of: (a) two limbs; (b) both eyes; (c) one limb and one eye; (d) speech and hearing; or (e) thumb and index finger of the same hand is payable only when such double loss is the result of the same accident.

Loss is defined as the severance of the hand or foot at or above the wrist or ankle joint; total and irrecoverable loss of entire sight, speech or hearing; and severance of two or more entire phalanges of both the thumb and index finger. To receive benefits, loss must be independent of sickness and all other causes.

Paralysis Benefits
When you suffer injuries that result in hemiplegia, paraplegia, quadriplegia, triplegia or uniplegia commencing within 60 days after the accident and continuing for one year, we will pay benefits as follows:

For Hemiplegia or Uniplegia	½ Principal Sum
For Paraplegia or Triplegia	¾ Principal Sum
For Quadriplegia	Principal Sum

Accident Only Comatose Benefit
If you lapse into an irreversible coma due to covered injuries received in an accident, benefits will be paid as follows. Beginning on the 32nd day of the coma, 5% of your Principal Sum will be paid per month over 20 months or until death, whichever comes first. Upon death, any remaining Principal Sum will be paid as provided in the policy. If any other benefits for this condition are payable under the policy only one of the amounts, the largest applicable, will be paid.

Seat Belt Benefit
If Injuries result in the Insured's death and at the time of the accident the Insured was: (a) the operator of or a passenger in a Private Passenger Automobile; and (b) utilizing a Seat Belt; a benefit equal to 10% of your Principal Sum will be paid. Seat Belt usage must be verified by a doctor, a coroner, a traffic officer or other person of competent authority.

Exposure and Disappearance Benefit
Benefits for exposure to the elements or the Insured's disappearance as incurred in a covered accident which results in the disappearance, sinking or damaging of a conveyance on which an Insured was riding, will be paid as follows:

1. If, (a) the Insured is unavoidably exposed to the elements; and (b) as a result of such exposure suffers Injuries for which benefits are otherwise payable, such Injuries will be covered under this policy.
2. If, (a) the Insured disappears; and (b) if the body of the Insured has not been found within 52 weeks after the date of such accident; it will be presumed, subject to no evidence to the contrary, that the Insured suffered loss of life as a result of Injuries covered by the policy.

BENEFIT REDUCTIONS

Principal Sum Benefits for covered individuals age 70 and over shall be payable according to the following schedule:

Ages	% of original Principal Sum
70 thru 74	65%
Age 75 until Retirement	50%
Retirement	Coverage Terminates

CONVERTED POLICY OPTION

A converted policy will be offered to the insured if the accidental death and dismemberment insurance under the policy terminates by ending your employment, ending your eligibility or if the policy ends for reasons other than non-payment of premium.

To obtain a converted policy, you must apply within 31 days after the policy ends and pay the first premium. If you have assigned ownership of coverage, the owner must apply for you. The converted policy will provide accidental death and dismemberment benefits. The premium will be based on the class of risk to which you belong, your age and the amount of coverage issued. The converted policy will take effect on the date you apply. The insured must be under the age of 70 to obtain a converted policy.

PAYMENT OF CLAIMS

Indemnity for loss of life will be payable in accord with the beneficiary designation made in writing by the Insured and on file with the Company. In the absence of such beneficiary designation, or in the event the designated beneficiary predeceases the Insured, indemnity for loss of life will be paid to the first of the following surviving beneficiaries: the Insured's: (a) lawful spouse; (b) child or children, jointly; (c) parents, jointly if both are living, or the surviving parent if only one survives; (d) brothers and sisters, jointly; (e) estate. Any other accrued indemnities unpaid at the Insured's death may, at Our option, be paid either to the Insured's beneficiary or to his or her estate.

DEFINITIONS

"Hospital" means any of the following places: (a) a place which is licensed or recognized as a general hospital by the proper authority of the state in which it is located; (b) a place operated for the care and treatment of resident inpatients with a registered graduate nurse (RN) always on duty and with a laboratory and X-ray facility; (c) a place recognized as a general hospital by the Joint Commission on the Accreditation of Hospitals; or (d) a place certified as a hospital by Medicare. Not included is a hospital or institution or a part of such hospital or institution which is licensed or used principally: (1) for the treatment or care of drug addicts or alcoholics; or (2) as a clinic, continued or extended care facility, skilled nursing facility, convalescent home, rest home, nursing home or home for the aged.

"Injuries" means accidental bodily injuries: (a) received while insured under this policy, and (b) resulting independently of sickness and all other causes.

"Irreversible Coma" means: (a) a state of unconsciousness in which there is a cessation of activity in the central nervous system as demonstrated by an electroencephalogram (using criteria established by the American Electroencephalography Society); and (b) a diagnosis of brain death by the attending physician.

Paralysis:
"Hemiplegia" means complete loss of function of one side of the body with involvement of the arm and leg.

"Paraplegia" means complete loss of function of the lower extremities of the body with involvement of both legs.

"Quadriplegia" means complete loss of function of both the upper and lower extremities of the body with involvement of both arms and legs.

"Triplegia" means complete loss of function of three limbs.

"Uniplegia" means complete loss of function of one limb.

"Seat Belt" means any factory-installed passive restraint device or child passive restraint device which meets published federal safety standards.

EXCEPTIONS

This plan does not cover: suicide, attempted suicide or intentionally self-inflicted injury while sane or insane (in Missouri, while sane only); injuries caused by an act of declared or undeclared war; injuries received while in the armed service (upon notice to us of entry into an armed service, the pro rata premium will be refunded); injuries received while acting as a pilot or crew member; injuries received while traveling as a passenger by air except as defined in the policy; or injuries resulting from the Insured's engagement in or attempt to commit a felony or being engaged in an illegal occupation.

This brochure summarizes the provisions of the policy issued to the Diocese of Winona. Should there be any discrepancy between the policy and this description, policy provisions will prevail.

Diocese of Winona-Rochester
Form B – 1 Insurance Enrollment For:

Basic Group (Term) Life (Policy #551767-18)
Long Term Disability (LTD) (Policy #551767-134)
& Accidental Death & Dismemberment (AD&D) (GMDA-BD6D)

☐ Beneficiary change only. This form cancels all prior designations. Complete your name, SS# and beneficiary information along with signature and date.
☐This includes employee name change – prior name was_____

Employee Name (last, first, middle initial)	Policyholder Name	
	Diocese of Winona-Rochester	
Employee Address (street, city, state, zip code)	Social Security Number	Date of Birth

Beneficiary* Information – Use additional sheet if needed

Name (last name, first, middle initial)	Relation to You:	Benefit %
If the Beneficiary(ies) named above are not living, then pay:		

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information

Request for Coverage Signature and Certification:

I understand that my Insurance coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and understand that a copy of this form will be made available to me at my request.

Employee Signature	Date	Work Phone	Home/Cell Phone

Important Information About Designation of Beneficiaries

Beneficiary Information

- Primary Beneficiary(ies) means the person(s) you choose to receive your life insurance benefits. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any primary beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining primary beneficiary(ies).

- Contingent Beneficiary(ies) means the person(s) you choose to receive your life insurance benefits only if all primary beneficiaries are disqualified or die before you. Please specify the percentage of the benefit you want paid to each beneficiary; these percentages should total 100%. If any contingent beneficiary is disqualified or dies before you, his/her percentage of the benefit will be paid to the remaining contingent beneficiary(ies).

- Minor Beneficiary(ies) — When you designate minors as beneficiaries, it is important to understand that insurance benefits may not be released to a minor child. They may, however, be paid to a court appointed guardian of the child's estate. The regulations governing minor beneficiaries vary by state.

- Trust — You may designate a valid trust as a beneficiary.

Types of Coverage Information

- Basic Life is life insurance provided by your employer for which they pay the premiums.

- Supplemental Life is life insurance elected by you for which you pay the premiums.

- If you wish to designate different beneficiaries for any of the above coverages, please complete a separate form.

General Information

- Updates to Your Beneficiary Designation — You can change your beneficiary designation at any time. You may wish to review your designation periodically.

- Consult an Attorney — This information is not intended to be relied on as legal advice. You may wish to get the assistance of an attorney to help ensure your beneficiary designation correctly reflects your intentions.

403(b) Diocese of Winona-Rochester Lay Employees Retirement Plan Information

Type of Plan:	Tax Deferred 403(b) - *Lincoln Alliance*®
Eligibility:	Employees, age 21 or older, who are normally scheduled to work 20 or more hours per week. Participation is effective at date of hire for eligible employees. Temporary employees are not eligible.
Employer Discretionary Contribution:	3% of employee's wages.
Employee Elective Deferral:	Participant may contribute, via payroll deduction, from 1% to 100% (even numbers only) of his/her wages up to the annual IRS limits. Participant may change his/her elective deferral percentage effective the first day of any given month. Your 403(b) deduction does not reduce your wages for purposes of calculating FICA (Social Security and Medicare) taxes. "Pre-tax" only refers to income taxes, therefore, we must apply the FICA tax rate to your *gross earnings.* If you elect a contribution rate of 100%, we must first withhold FICA taxes and then you can defer 100% of your remaining compensation.
Employer Matching Contribution:	1% of employee's wages if the employee contributes 1%; 2% of employee's wages if the employee contributes 2%; 3% of the employee's wages if the employee contributes 3% or more; otherwise 0%.
Vesting - Employer Contributions:	20% vesting (ownership) per full year of eligible employment. Participant is 100% vested after 5 years.
Vesting - Employee Contributions:	Participant is always 100% vested in his/her elective deferral contributions.
Investments Options:	Participant directs all contributions to a variety of widely-recognized mutual funds. Participant also has the option to select a *LifeSpan*® asset allocation model, which provides allocation among the various investment options, based on a targeted retirement date. Participant may change investment options at any time.
Default Investment Election:	Participants who do NOT make individual investment elections for their contributions will automatically be invested in a *LifeSpan*® Target Date Model based on the participant's date of birth and the date closest to when the participant will reach the plan's normal retirement age of 65.
Loans:	Participant may borrow from his/her elective deferral account balance. Minimum loan amount is $1,000 and only one loan may be outstanding at a time. Loan must be repaid within 5 years, except loans used to purchase primary residence.

Withdrawal of Funds:	Participant may be eligible to withdraw money from the vested account balance when the following events occur: - Reach age 59½ - Upon retirement - Upon death - Upon total and permanent disability - A financial hardship, as defined by IRS guideline - No longer employed within the Diocese of Winona-Rochester *Please note that distribution restrictions may apply to certain accounts under each of the above events. Taxes will be due upon distribution and if taken before age 59½, may be subject to an additional 10% federal tax penalty.*
Fees:	The mutual funds in this program contain operating expenses just like all mutual funds.

How to Enroll

1. Complete the Salary Reduction Agreement, indicating the percentage of your wages that you choose to contribute (from 0% - 100%) to the plan each payroll.
2. Return the Salary Reduction Agreement to the person who handles payroll at your parish/school/cemetery/institution.
3. Your parish/school will provide the necessary data to the Diocese of Winona-Rochester to set up your account with *Lincoln Alliance*®.

Account Access

Lincoln Alliance® will mail you a letter containing instructions to access your account by phone and on the internet.

1. Phone – toll free @ 1-800-234-3500
    - The last four digits of your Social Security number is required to access your account.
    - You will be given prompts in the call to complete registration.
2. Internet – *www.lfg.com*
    - When in the website click on "Register Now" where you will register and establish a user name and password. You will be able to register after your first month's wages have been uploaded.

When accessing your account for the first time, either by phone or by internet, you should:

1. Make your investment choices
2. Make your beneficiary elections

Lincoln Alliance Program® Contact Information

CUSTOMER SERVICE
1-800-234-3500
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.lfg.com

RETIREMENT CONSULTANT
Wayne Lanum, CRPC
Phone: 614-601-3825 Office
E-mail: Wayne.Lanum@LFG.com

DIOCESE OF WINONA-ROCHESTER

403(b) LAY EMPLOYEES RETIREMENT PLAN

Participation and Form Directions

Eligible participants are lay employees who are age 21 and older and are scheduled to work 20 or more hours per week, or at least .5 FTE during the academic year. Temporary employees are not eligible. All benefit eligible employees receive the 3% employer discretionary contribution.

If you intend to process a year-end cash gift or bonus to employees, this must be included in payroll processing as this is taxable income to employees. Bonus payments are includable compensation for the 403(b). See DOW-R Finance Manual.

ENROLLMENT OF A PARTICIPANT:

1. Lincoln Alliance® Program Enrollment Book

Copies of the enrollment booklet may be requested from the Diocese of Winona-Rochester Employee Benefits Department or you may direct the employee to the on-line version of the document on the diocesan web site under "Lincoln 403b Information and Resources" at the following address: https://www.dowr.org/offices/human-resources/benefits.html

2. 403(b) DOW-R Lay Employees Retirement Plan Information C-1

This document provides the new participant with a brief summary of the 403(b) plan benefit, along with information regarding the process of online enrollment, investment elections and beneficiary elections.

3. Salary Reduction Agreement Form C-2

This is the only document the participant needs to return to you for enrollment in to the plan. All benefit-eligible employees whose location participates in the DOW-R 403(b) plan are required to complete the form.

a. In Step 2, the participant will either elect or decline to contribute through salary reduction. The participant may elect to contribute to either or to both the Traditional pre-tax and Roth plan.
b. Elective deferrals are required to be a percentage of wages (not dollars). The percentage must be a whole number, not a fraction.
c. Employee signature and date are required; please leave the plan administrator signature section blank.

The Salary Reduction Agreement needs to be uploaded to Dropbox to the Diocese of Winona-Rochester Employee Benefits Department. File copies will be uploaded back to the location after processing.

PARTICIPANT CHANGE REQUESTS:

1. Salary Reduction Agreement Form C-2

This form is also used for current participants to change their elective deferral, as well as change their mailing address with the Lincoln Alliance® Program.

a. The effective date of a change in salary deferral must be coincide with the first payroll of any given month. Typically, forms must be to payroll 3 to 5 business days before the first of the month. Mid-month change in salary deferral percentage is not allowed.
b. Elective deferrals are required to be a percentage of wages (not dollars). The percentage must be a whole number, not a fraction.
c. Employee signature and date are required; please leave the plan administrator signature section blank.

The Salary Reduction Agreement needs to be uploaded to Dropbox to the Diocese of Winona-Rochester Employee Benefits Department. File copies will be uploaded back to the location after processing.

2. Other Changes

All other requests for changes (beneficiary designation, change in investment elections, transfer of investment assets, etc.) are handled by the participant directly with Lincoln. Please encourage your employees to designate their beneficiary with Lincoln. You may provide the following contact information to the participant:

Lincoln Alliance Program®

CUSTOMER SERVICE
1-800-234-3500
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.lfg.com

RETIREMENT CONSULTANT
Wayne Lanum, CRPC
Phone: 614-601-3825 Office
E-mail: Wayne.Lanum@LFG.com

TERMINATING/RETIRING EMPLOYEES:

403(b) Pension Plan Information for Terminating/Retiring Participants (C-6)

This document provides the participant with all the necessary information related to vesting, distributions, rollovers, and direct transfers of their account(s). Contact information for both the Lincoln Multi-Fund® Annuity and the Lincoln Alliance Program® are provided.

Diocese of Winona-Rochester

403(b) Lay Employees Retirement Plan

Information for Terminating/Retiring Participants

What types of contributions are in my 403(b) account?

There are two sources of contributions that have been made to your diocesan 403(b) lay retirement plan:

1. ***Employee Contributions***: The contributions you personally made to the plan are 100% vested (owned by you).

2. ***Employer Contributions****:* The contributions made to your account by your employer are 20% vested (owned by you) per full year of covered employment. The vesting schedule of the Diocese of Winona-Rochester Plan is 20% per year, with full vesting after 5 years or upon reaching age 60, whichever occurs first.

What happens to my vested 403(b) account balance?

Terminated participants have the following options for their vested 403(b) account balance:

1. ***Distribution*** – You may request a distribution of funds from your vested account balance.
    a. ***Pre-Tax Contributions (Traditional):*** The distribution will be considered taxable income in the year of distribution and a 20% federal tax will be withheld from the distribution. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.
    b. ***After-Tax Contributions (Roth):*** The distribution will not be considered taxable income in the year of distribution if your account has been held for at least five years and you are at least age 59 ½. Early withdrawal penalties of 10% may also apply if you are below 59 ½ years of age.

2. ***Direct Rollover or Transfer*** – You may request a transfer of your vested balance to another qualified retirement plan or an individual IRA.

3. ***Maintain your account*** - Terminated participants with a vested balance of less than $5,000 will have their vested account balance automatically transferred to a Lincoln Small Account IRA if they do not initiate a distribution, direct rollover, or transfer. Terminated participants with a vested account balance of $5,000 or greater may choose to retain their vested balance in the plan for future distribution. Participants must begin to take a distribution from the plan at age 73, called Required Minimum Distribution (RMD).

Who do I contact and where can I obtain the necessary forms?

First determine which Lincoln retirement account(s) you have; you may have one account or two separate accounts depending on your individual situation. Although all accounts are through Lincoln, each type of account has different contact information and different forms to

complete for account distribution or transfer. Quarterly statements are provided to participants and you may also refer to those statements to determine which account(s) you have a balance in.

Please keep the following items in mind when contacting Lincoln regarding your account(s):

- Effective 3/1/2010, all employee and employer contributions to the 403(b) retirement plan have been invested in the **Lincoln Alliance Program®**
- Prior to 3/1/2010, all employee and employer contributions to the 403(b) retirement plan were invested in **Lincoln Multi-Fund® Annuity**. Participants with Multi-Fund® accounts were given the opportunity to complete contract exchange paperwork to transfer those assets to the Lincoln Alliance Program®.

Lincoln Contact Information

To obtain information on your account(s) and plan forms, please use the following:

Diocese of Winona-Rochester 403(b) Lay Retirement Plan Retirement Consultant:

Wayne Lanum, CRPC

Email: Wayne.Lanum@LFG.com

Phone: 614-601-3825 Office

Lincoln Alliance Program® (Effective April 1, 2018)

CUSTOMER SERVICE
1-800-234-3500
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

Lincoln Multi-Fund® Annuity

CUSTOMER SERVICE
1-800-454-6265
Mon - Fri 7 am - 7 pm
24 Hour Voice Response
www.LFG.com

MAILING ADDRESS
The Lincoln National Life Insurance Company
Attention - Annuities Operations
PO Box 2340
Fort Wayne, IN 46801-2340

Lincoln Financial Group®
The Lincoln National Life Insurance Company

For use with:
Lincoln Alliance® program

Diocese of Winona-Rochester Lay Employees Retirement Plan DOW-001

Salary reduction agreement

Location Code: _____ **Effective Date:** _____

PLEASE PRINT CLEARLY

Step A: Participant Information

Name: _____ Employee ID: _____
Last First Middle

Address: _____
Street City State ZIP

Birth Date: _____ ☐ Married ☐ Male Daytime Phone: _____

Date of hire: _____ ☐ Not married ☐ Female Evening Phone: _____

Step B: Decide how much to save

Choose one:

☐ **I elect to contribute this percentage** Pretax _____% Roth _____%

☐ **I do not want to contribute through salary deferrals.** Please complete the remainder of the form.

Step C: Read these statements carefully

- The employer will reduce your pay by the amount indicated (in **Step B** above) per pay period. The employer will send this amount to the provider as contributions.
- The first payroll deduction will take place as soon as administratively possible after we receive this form.
- While employment continues, this agreement legally binds both you and the employer for amounts deferred while it is in effect. A new agreement must be submitted to change your percentage.
- This agreement will apply only to amounts not yet currently available to you. It will not apply to any amounts earned after the agreement is terminated.
- If you do not provide investment choices, your contributions will be invested in the default fund chosen by your employer.

Step D: Signatures

By signing below, I certify that:

- I have read, understand and agree to the terms of the **Salary Reduction Agreement**. The signature of the plan administrator certifies that the plan administrator also agrees to the **Salary Reduction Agreement.**

_____ _____
Participant's Signature Date

Plan Administrator

_____ _____
Plan administrator's signature Date

Return this form to:
Your employer's Human Resources department

EM81799-AL-DOW-001 11/12
PAD1210-0797

DIOCESE OF WINONA-ROCHESTER

FLEXIBLE BENEFITS

Participation and Form Directions

Eligible employees are those who work at least 20 hours a week or at least one-half academic load during the plan year. Employees must be 21 years of age or older to participate. Temporary employees are not eligible. Employees may enroll in the plan at the beginning of each plan year.

New employees have 30 days from their initial date of employment to enroll. After that time, they can only enroll when the new plan year starts. There are certain qualifying events such as death, birth, adoption, change in job status, etc. that may allow an employee to join during the plan year or change their allocation. Contact the Employee Benefits Coordinator if you feel you have an employee with a qualifying event.

FORMS REQUIRED TO ENROLL OR WAIVE PARTICIPATION:

1. **Flexible Benefits Information**

   All employees have online access to the Diocese of Winona-Rochester flexible benefits information at https://www.dowr.org/offices/human-resources/index.html. This information should be reviewed with the employee, so they are familiar with it.

2. **Enrollment Form - Form D-2** (Required completion for new employees only – whether enrolling or waiving)

   PURPOSE: To authorize the employer to withhold from wages, the amount designated by the employee, to be allocated to the flexible benefit plan.

   a) New Employees - This form is to be completed within the first 30 days of employment with the effective date as the first of the month following the date of hire.
      1. The employee shall make an annual election to either participate in each of the two individual flex plan accounts or waive (decline) participation in each flex plan account.
         - Medical Flexible Spending Account / Limited FSA
         - Dependent Care Flexible Spending Account
      2. The signature of the employee is required at the bottom of the form, along with the date signed.

   b) Current Employees
      1. Open enrollment – This form only needs to be completed if the employee participates in flexible spending. This form is an online form only.
      2. Qualifying event – See below

All application forms are to be returned to the Diocese of Winona-Rochester; online forms are automatically submitted securely to the DOW-R employee benefits coordinator. A copy will be returned to the location showing flexible spending costs by participating employee with the monthly amount DOW-R will be charging the location for the employee.

CLAIM FORM/Request for Reimbursement – Medical Expense and Daycare Expense

PURPOSE: Employee can use the Claim Form to request reimbursement from their medical care and dependent care spending accounts.

This form is used for medical, dental, over-the-counter, and dependent care expenses.

- You may submit a claim through your online account, through the WEX benefits mobile app, or manually (fax, mail, email).

WEX DEBIT CARD

The WEX debit card can be used to pay for eligible out-of-pocket expenses.

A debit card is automatically issued to all new employees who elect a medical flexible spending account. If the employee enrolled in 2023 and is enrolling in 2024 during open enrollment, they will not receive a new debit card. Only transactions at medical, dental, and vision providers or merchants are approved for plans that reimburse medical, dental, and vision expenses. The employee may have to provide substantiation for a purchase, which requires online completion on their WEX account.

Notes: Dental expenses typically require substantiation because most claims are covered by dental insurance, while other dental expenses such as teeth whitening, are not a covered expense. Vision claims may also require substantiation because of possible insurance and/or uncovered expenses.

FORMS REQUIRED FOR QUALIFYING EVENT OR STATUS CHANGE

Qualifying Event

PURPOSE: To notify the plan administrator of changes, which affect the employee's rights and obligations under the flexible benefits plan.

The employee may elect to change their Medical/Limited Flexible Benefits election ONLY in the event of change in job status of employee or their spouse, birth or adoption, death, marriage, or divorce. The election change must be directly related to the event, which causes the status change.

Upon termination of employment, the employee may elect to revoke their election or continue participating in the flexible benefits plan for the health care spending account only. COBRA flex information will be sent to the terminating employee through our third party vendor, Alerus. If the employee chooses to continue to participate, their contributions are made onan after tax basis to Alerus. The employee can then seek reimbursement for

eligible medical expenses for the rest of that plan year. If the employee chooses not to continue participation, they may seek reimbursement for eligible medical expenses incurred only through the date of termination.

An employee may change their dependent care FSA election if they experience a qualifying life event. These events include: Change in marital status; change in the number of dependents; increase due to birth, adoption or marriage; decrease due to death, divorce or loss of eligibility; gain or loss of eligibility due to a change in participant, spouse or dependent employment status; change in daycare providers; child turning age 13; increase or decrease in the cost of qualifying daycare expenses; judgement, decree or order requiring a change in coverage.

wexinc.com
868-451-3399

Diocese of Winona-Rochester Group

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM

January 1 – December 31, 2024 Calendar Year Plan

I waive the following:
☐ **Medical/Limited Flex**
☐ **Dependent Care Flex**

Step 1: Employee Information – Required Fields

Last Name: _____ First Name: _____ MI: _____

SSN#: _____ Daytime Phone: _____ Marital Status (Married/Single): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Date of Birth: _____ / _____ / _____

Step 2: Waiving Coverage (Note: Only complete this step if you are NOT electing to enroll in a Flexible Spending Account)

Participant Signature: **Date:**

Step 3: Enrollment and Election Information (Effective Date: Begins January 1 or 1st of the month following date of hire)

A. Medical Flexible Spending Account - If you have an HSA, you are not eligible to enroll in this account.

DOW-R minimum $150; DOW-R maximum $3,050

☐ I want to contribute a total of $ _____ during this plan year to my Medical Flexible Spending Account.
I understand this amount will be deducted from my pay throughout the plan year.

B. Limited FSA - If you have an HSA, you are eligible to enroll in this account.

Are you or your spouse participating in a Health Savings Account (HSA)? If yes, your limited FSA must be limited to dental and vision expense reimbursement until the IRS Statutory Deductible has been met. Contact "WEX" to remove the limit when your deductible is met.

DOW-R minimum $150; DOW-R maximum $3,050

☐ I want to contribute a total of $ _____ during this plan year to my Limited Flexible Spending Account.
I understand this amount will be deducted from my pay throughout the plan year.

C. Dependent Care Flexible Spending Account:

DOW-R minimum $150; IRS maximum: $5,000 ($2,500 if married but filing separate tax returns)

☐ I want to contribute a total of $ _____ during this plan year to my Dependent Care Flexible Spending Account. I understand this amount will be deducted from my pay throughout the plan year.

Flexible Spending Account Enrollment Form Signature:

All enrollees in medical, limited FSA, and/or dependent care must sign/date

I authorize my employer to reduce my pay based on a per-pay-period for the annual amount indicated above. I understand my reduction is for one flex plan year and that I cannot change or revoke my election unless I experience a qualifying event in accordance with Internal Revenue Code Section 125 and submit my request within a reasonable amount of time as deemed by the IRS and my employer. I am aware of the plan's forfeiture provision and that my Social Security and federal unemployment benefits may be reduced because of my reduced salary for tax purposes. Further, I authorize the release of any information necessary to substantiate claims submitted against my Flexible Spending Account.

Participant Signature: _____ **Date:** _____

Questions? Contact Benefits (Julia Sandsness) at the Diocese of Winona-Rochester at (507) 858-1268 or email benefits@dowr.org or contact "WEX" at (866) 451-3399.

Location - Upload completed forms to your location's Dropbox.

Benefit Office	Location Payroll Reduction(s)	Location Name/#	
FLEX	Effective Date: _____	Medical Mo Amt: _____	Dependent Care Mo Amt: _____

DIOCESE OF WINONA-ROCHESTER

SUPPLEMENTAL LIFE INSURANCE

Participation and Form Directions

Administered by Unum Provident

Eligible employees are those who work at least 20 hours a week or at least one-half academic load during the plan year. Temporary employees are not eligible. Employees are insured on the first of the month coincident with or following the date of hire.

FORM REQUIRED TO ENROLL AN EMPLOYEE:

1. Term Life Insurance Enrollment Form E-1

PURPOSE: To provide information to participate in the supplemental life plan.

The employee should complete the form by completing their own information on the top of the first page. If the employee is enrolling the spouse, the spouse's name and date of birth is needed. Children's names and birth dates are not needed. Put in the amount elected for coverage for employee, spouse and/or child(ren). The amount of coverage will need to be the next higher multiple of $10,000 for employee, the next higher multiple of $5,000 for spouse and the next higher multiple of $2,000 for child. If taking coverage beneficiary information needs to be completed. An employee signature, date and phone number is needed at the bottom of the form.

2. Evidence of Insurability Form 1143-01MN

If the employee chooses coverage above the guaranteed amount (over $200,000 for employee and/or over $25,000 for spouse), the employee needs to complete the Evidence of Insurability Form (EOI). The employee needs to complete the questionnaire in full to prevent denial of coverage. An online questionnaire is the preferred method of submittal and a link may be obtained by contacting benefits@dowr.org. If the employee completes the paper copy, be sure to have the employee sign and date the form. The evidence of Insurability Form should be sent to the diocese or directly to UNUM at:

Mail: PO Box 9783-5083, Portland, ME 04104
Fax: 207-771-4022
E-mail: nasateamimageid@unum.com

3. Term Life Insurance Coverage Highlights E-3

Each employee should be given the Term Life Insurance Coverage Highlights. A detailed Summary Plan booklet outlining the supplemental life benefit is available on the diocesan website at www.dow.org in the Human Resources department.

FORMS REQUIRED FOR CHANGES TO EXISTING EMPLOYEES:

1. **Term Life Insurance Enrollment Form E-1**

   PURPOSE: To change beneficiary(s) to receive benefits upon death of policy holder, qualifying event, change employee's name or address.

   Employee should complete a new Term Life Insurance Enrollment Form (E-1). Forms should be returned to the Diocese of Winona-Rochester Benefits.

FORM REQUIRED TO FILE SUPPLEMENTAL LIFE CLAIMS:

Claim for Life Insurance Benefits

The employer should contact the diocese and the appropriate claim for benefits form will be provided.

TERMINATING EMPLOYEES:

Supplemental Group Life Options for Terminating/Retiring Participants

PURPOSE: The Diocese of Winona-Rochester's third party vendor, Alerus, informs employees of their rights pertaining to the term supplemental life policy and confirms their decision to elect continued coverage or terminate coverage.

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan. You also have the opportunity to have coverage for your dependents.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: November 1, 2014

PLAN YEAR:

September 1, 2020 to January 1, 2022 and each following January 1 to January 1

IDENTIFICATION NUMBER: 604947 001

ELIGIBLE GROUP(S):

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer

MINIMUM HOURS REQUIREMENT:

Employees must be working at least 20 hours per week.

WAITING PERIOD:

For employees in an eligible group before November 1, 2016: None

For employees entering an eligible group on or after November 1, 2016: First of the month coincident with or next following the date of active employment

You must be in continuous active employment in an eligible group during the specified waiting period.

WHO PAYS FOR THE COVERAGE:

For You:

You pay the cost of your coverage.

For Your Dependents:

You pay the cost of your dependent coverage.

ELIMINATION PERIOD:

Premium Waiver: 90 days

Disability-based benefits begin the day after Unum approves your claim and the elimination period is completed.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

Amounts in $10,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $10,000, if not already an exact multiple thereof.

AMOUNT OF LIFE INSURANCE AVAILABLE IF YOU BECOME INSURED AT CERTAIN AGES OR HAVE REACHED CERTAIN AGES WHILE INSURED

If you have reached age 70, but not age 75, your amount of life insurance will be:
- 65% of the amount of life insurance you had prior to age 70; or
- 65% of the amount of life insurance shown above if you become insured on or after age 70 but before age 75.

There will be no further increases in your amount of life insurance.

If you have reached age 75 or more, your amount of life insurance will be:
- 50% of the amount of life insurance you had prior to your first reduction; or
- 50% of the amount of life insurance shown above if you become insured on or after age 75.

There will be no further increases in your amount of life insurance.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR INSURANCE OVER:

$200,000

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

$10,000

OVERALL MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOU:

The lesser of:
- 5 x annual earnings; or
- $500,000.

AMOUNT OF LIFE INSURANCE FOR YOUR DEPENDENTS

Spouse:

Amounts in $5,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $5,000, if not already an exact multiple thereof.

THE AMOUNT OF YOUR SPOUSE'S LIFE INSURANCE WILL REDUCE BY THE SAME PERCENTAGE AND AT THE SAME TIME YOUR LIFE INSURANCE REDUCES.

EVIDENCE OF INSURABILITY IS REQUIRED FOR THE AMOUNT OF YOUR SPOUSE'S INSURANCE OVER:

$25,000

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

$5,000

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR SPOUSE:

The lesser of:
- 100% of your amount of insurance (Summary of Benefits Identification #604947-001 and Summary of Benefits Identification #551767-035 combined); or
- $500,000.

Children:

Amounts in $2,000 benefit units as applied for by you and approved by Unum.

All amounts are rounded to the next higher multiple of $2,000, if not already a multiple thereof.

MINIMUM BENEFIT OF LIFE INSURANCE FOR YOUR CHILDREN:

$2,000

MAXIMUM BENEFIT OF LIFE INSURANCE FOR YOUR CHILDREN:

Attained age at death:

Live birth to 14 days: $1,000
14 days to 6 months: $1,000
6 months to age 26:

The lesser of:
- 100% of your amount of insurance (Summary of Benefits Identification #604947-001 and Summary of Benefits Identification #551767-035 combined); or
- $10,000.

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Accelerated Benefit

Conversion

Portability

NOTE: Portability under this plan is available to an insured spouse in the event of divorce from an insured employee, subject to all terms and conditions otherwise applicable to ported spouse coverage. Conversion is available to insured dependent child(ren), subject to all terms and conditions otherwise applicable to converted dependent coverage.

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

Diocese of Winona-Rochester
Policy # 604947

Please read carefully the following description of your Unum Term Life insurance plan.

Your Plan

Eligibility

All full-time and part-time employees of the Diocese of Winona-Rochester who work at least 20 hours per week or are contracted for at least one half academic load and school employees contracted and non-contracted, whose employment corresponds with the academic school year and work at least 20 hours per week or are contracted for at least one half academic load in active employment in the United States with the Employer.

*Note: Disabled children over the maximum child age may be eligible for benefits, please see your plan administer for more details.

Coverage Amounts

Your Term Life coverage options are:

Employee: Up to 5 times salary in increments of $10,000.
Up to a maximum of the lesser of 5x salary or $500,000.

Spouse: Up to 100% of employee amount in increments of $5,000.
Not to exceed $500,000. Benefits will be paid to the employee.

Child(ren): Up to 100% of employee coverage amount in increments of $2,000.
Not to exceed $10,000 (up to age 26)
The maximum death benefit for a child between the ages of live birth and 6 months is $1,000. Benefits will be paid to the employee.

The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have.

If you have coverage under policy number 551767-035 or elect coverage under 604947 – 001 for yourself, you are eligible to elect dependent coverage for your spouse only, your dependent children only or both.

Coverage amount(s) will reduce according to the following schedule:

Age:	Insurance Amount Reduces to:
70	65% of original amount
75	50% of original amount

Coverage may not be increased after a reduction.

Guarantee Issue

If you and your eligible dependents enroll within 31 days of your eligibility date, you may apply for any amount of Life insurance coverage up to $200,000 for yourself and any amount of coverage up to $25,000 for your spouse. Any Life insurance coverage over the Guarantee Issue amount(s) will be subject to evidence of insurability. If you and your eligible dependents do not enroll within 31 days of your eligibility date, you can apply for coverage only during an annual enrollment period or change in status and will be required to furnish evidence of insurability for the entire amount of coverage.

If you and your eligible dependents enroll within 31 days of your eligibility date and later wish to increase your coverage, you may do so during annual enrollment or change in status. You and your eligible dependents may purchase additional Life coverage up to the Guarantee Issue amounts without evidence of insurability. Life coverage over the Guarantee Issue amounts will require evidence of insurability and require approval by Unum's Medical Underwriters.

Please see your Plan Administrator for your eligibility date.

Term Life Coverage Rates

Rates shown are your Monthly deduction:

Age Band	Employee per $1,000	Spouse per $1,000	Child per $1,000
- 24	$.030	$.052	$.256
25-29	$.035	$.058	
30-34	$.050	$.070	NOTE: The
35-39	$.080	$.094	premium paid for
40-44	$.095	$.132	child coverage is
45-49	$.140	$.207	based on the cost of
50-54	$.215	$.326	coverage for one
55-59	$.410	$.500	child, regardless of
60-64	$.600	$.892	how many children
65-69	$.962	$1.558	you have.
70-74	$1.780	$2.784	
75+	$2.050	$5.398	

NOTE: Your rate will increase as you age and move to the next age band.

Insurance Age

Your rate is based on your insurance age. To calculate your insurance age, subtract your year of birth from the year your coverage becomes effective.

Spouse rate is based on employee's insurance age.

To calculate your cost, complete the following by selecting your coverage amount and rate (based on your insurance age).

Term Life Calculation Worksheet

Coverage Amount		Increment	Rate		Monthly Cost
Employee	$_____	÷ $1,000 x	$_____	=	$_____
Spouse	$_____	÷ $1,000 x	$_____	=	$_____
Children	$_____	÷ $1,000 x	$_____	=	$_____
		YOUR MONTHLY COST		=	$_____

_____	x 12 =	_____	÷	_____	=	_____
Your Monthly Cost		Annual Cost		# Paychecks per Year		**COST PER PAYCHECK***

Additional Benefits

Life Planning Financial & Legal Resources

This personalized financial counseling service provides expert, objective financial counseling to survivors and terminally ill employees at no cost to you. This service is also extended to you upon the death or terminal illness of your covered spouse. The financial consultants are master level consultants. They will help develop strategies needed to protect resources, preserve current lifestyles, and build future security. At no time will the consultants offer or sell any product or service.

Portability/Conversion

If you retire, reduce your hours or leave your employer, you can take this coverage with you according to the terms outlined in the contract. However, if you have a medical condition which has a material effect on life expectancy, you will be ineligible to port your coverage. You may also have the option to convert your Term life coverage to an individual life insurance policy.

Accelerated Benefit

If you become terminally ill and are not expected to live beyond a certain time period as stated in your certificate booklet, you may request up to 75% of your life insurance amount up to $500,000 without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary(ies). This feature also applies to your covered dependents.

Waiver of Premium

If you become disabled (as defined by your plan) and are no longer able to work, your premium payments will be waived during the period of disability.

Retained Asset Account

Benefits of $10,000 or more are paid through the Unum Retained Asset Account. This interest bearing account will be established in the beneficiary's name. He or she can then write a check for the full amount or for $250 or more, as needed.

Limitations/Exclusions/ Termination of Coverage

Suicide Exclusion

Life benefits will not be paid for deaths caused by suicide in the first twenty-four months after your effective date of coverage.

No increased or additional benefits will be payable for deaths caused by suicide occurring within 24 months after the day such increased or additional insurance is effective.

Termination of Coverage

Your coverage and your dependents' coverage under the Summary of Benefits ends on the earliest of:

- The date the policy or plan is cancelled;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The last day of the period for which you made any required contributions;
- The last day you are in active employment unless continued due to a covered layoff or leave of absence or due to an injury or sickness, as described in the certificate of coverage;
- For dependent's coverage, the date of your death.

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends;
- The date your dependent ceases to be an eligible dependent;
- For a spouse, the date of divorce or annulment.

Unum will provide coverage for a payable claim which occurs while you and your dependents are covered under the policy or plan.

Next Steps

How to Apply

To apply for coverage, complete your enrollment form within 31 days of your eligibility date.

All employees: If you apply for coverage after your effective date, or if you choose coverage over the guarantee issue amount, you will need to complete a medical questionnaire which you can get from your Plan Administrator. You may also be required to take certain medical tests at Unum's expense.

Effective Date of Coverage

Please see your Plan Administrator for your effective date.

Delayed Effective Date of Coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent Spouse and/or Child: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

"Totally disabled" means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:

- **is confined in a hospital or similar institution;**
- **is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;**
- **is cognitively impaired;**
- **is receiving or is entitled to receive any disability income from any source due to**
- **any sickness or injury;**
- **is receiving chemotherapy, radiation therapy or dialysis treatment;**
- **is confined at home under the care of a physician for a sickness or injury; or**
- **has a life threatening condition.**

Your dependent children:

- **are confined in a hospital or similar institution;**
- **are receiving chemotherapy, radiation therapy or dialysis treatment; or are confined at home under the care of a physician for a sickness or injury.**

Changes to Coverage

Each year at annual enrollment you and your eligible dependents will be given the opportunity to change your Life coverage. You and your eligible dependents may purchase additional Life coverage up to the Guarantee Issue amounts without evidence of insurability if you are already enrolled in the plan. Life coverage over the Guarantee Issue amounts will be medically underwritten and will require evidence of insurability and approval by Unum's Medical Underwriters. The suicide exclusion will apply to any increase in coverage.

Questions

If you should have any questions about your coverage or how to enroll, please contact your Plan Administrator.

Diocese of Winona-Rochester

Insurance Enrollment Form For: Supplemental (Term) Life (Policy #604947-001)

Please print legibly and complete this form in its entirety.

Location_____

☐ Beneficiary change only. This form cancels all prior designations. Complete your name, SS# and beneficiary information along with signature and date.
☐This includes employee name change – prior name was_____

Application Type:
☐ **NEW HIRE ONLY: ☐ Enroll OR ☐ Waive enrollment**

☐ **QUALIFYING EVENT: Describe:** Date of Event

☐ **Annual Enrollment:** To make changes to existing elections and/or information. The elections/information you indicate will replace your prior elections/information on file with Unum. **Note: If you do not wish to make any changes, do not complete this form. Please contact your plan administrator with any questions.**

Employee Name (last, first, middle initial)	Policyholder Name	
	Diocese of Winona-Rochester	
Employee Address (street, city, state, zip code)	Social Security Number	Date of Birth

COVERAGE ELECTIONS: Please indicate below the coverage amounts you would like to select for you and your spouse and/or child, if applicable. If you are taking coverage for your spouse, please include spouse's name and date of birth. Dependent life coverage amounts cannot exceed 100% of your life coverage amounts. Any coverage amounts left blank will result in a coverage amount of $0.

Amount of life coverage selected for:

You: $ ☐☐☐,☐☐☐,☐☐☐ Your Spouse: $ ☐☐☐,☐☐☐ Your Child: $ ☐☐,☐☐☐

Spouse First & Last Name

Spouse Date of Birth

Note: If you have chosen Life coverage over the Guarantee Issue amount of $200,000 for you or $25,000 for your spouse, you will also need to complete an Evidence of Insurability form. The amount of Life coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective in accordance with the terms of the policy. **If you DO NOT APPLY FOR coverage for you or your dependent(s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage.**

Beneficiary* Information - use an additional sheet if necessary

Name *(last name, first, middle initial)*:	**Relation to You:**	**Benefit %:**
If the beneficiary(ies) named above are not living, then pay:		

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information

Request for Signature and Certification: *I have read and understand the included "Limitations and Exclusions*".* I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective unless I waive coverage. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ Date _____ Work Phone _____ Home/Cell Phone _____

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

Please be aware that your coverage may be impacted by certain limitations and exclusions including, but not limited to, the following:

Limitations and Exclusions*

Delayed Effective Date

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Dependent Spouse and/or Child: Insurance coverage will be delayed if that dependent is totally disabled on the date that insurance would otherwise be effective. Exception: infants are insured from live birth.

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Your dependent spouse:

- **is confined in a hospital or similar institution;**
- **is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness;**
- **is cognitively impaired;**
- **is receiving or is entitled to receive any disability income from any source due to**
- **any sickness or injury;**
- **is receiving chemotherapy, radiation therapy or dialysis treatment;**
- **is confined at home under the care of a physician for a sickness or injury; or**
- **has a life threatening condition.**

Your dependent children:

- **are confined in a hospital or similar institution;**
- **are receiving chemotherapy, radiation therapy or dialysis treatment; or**
- **are confined at home under the care of a physician for a sickness or injury.**

Exclusion for Suicide:

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.

This Suicide Exclusion does not apply to Washington residents.

Please see your Plan Administrator [or your Policy] for a complete listing of applicable limitations and exclusions.

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER