SHORE UP! INC.

COMMUNITY ACTION

Helping People. Changing Lives.

# NEW

# EMPLOYEE

# PACKET

**CRIMINAL BACKGROUND DECLARATION**

I, _____, declare that I have not been convicted of a criminal offense, nor am I the subject of pending charges for any felony, theft, crime of violence or moral turpitude.

I agree to have a criminal background investigation conducted by the Maryland State Police. I understand that if the investigation reveals any criminal offense conviction or pending charges, it is grounds for my employment with SHORE UP! Inc. to be terminated.

_____
Employee's Signature

_____
Date

Sworn and subscribed to before
me this _____ day of

_____ 20_____

_____
Notary Public

ADDITIONAL INFORMATION

AUTHORIZATION FOR AUTOMATED DEPOSITS (Direct Deposit)

COMPANY NAME: **SHORE UP! Inc.**

COMPANY ID NUMBER: **52-0886996**

I (we) hereby authorize SHORE UP! INC , hereinafter called COMPANY, to initiate credit entries and to initiate, IF NECESSARY, DEBIT AND ADJUSTMENTS FOR ANY CREDIT ENTRIES IN ERROR to my (our) checking [ ] savings [ ] account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

DEPOSITORY NAME _____

BRANCH _____

CITY _____ STATE _____ ZIP _____

ROUTING/ABA # _____ ACCOUNT # _____

This authority is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY a reasonable opportunity to act on it.

NAME(S) _____

ID NUMBER _____

SIGNATURE _____ DATE _____

Please attach a voided check if a checking account is selected.

---

**FOR COMPANY USE ONLY**

Date Received _____

Processed By _____

SHORE UP! INC.

Helping People. Changing Lives.

Form #618

Freddy L. Mitchell
Executive Director

## DRUG FREE WORKPLACE REGULATIONS

The Drug-Free Workplace Act, enacted November 18, 1988 requires certain employers who receive funds from the federal government to comply with regulations aimed at reducing the impact of drugs on the workplace. In accordance with this Act (Public Law 100-690) the following drug-free policy statements are immediately effective.

1. Employees are expected and required to report for work on time and in appropriate mental and physical condition for work. It is the intent of SHORE UP! Inc. to maintain a drug-free, healthful, safe, and secure work environment.

2. The unlawful manufacture, distribution, dispensation, possession or use of controlled substances on agency premises, or while conducting agency business off company premises, is absolutely prohibited. Violations of this policy will result in disciplinary action, up to and including termination, and may have legal consequences.

3. SHORE UP! Inc. also recognizes drug dependency as an illness and a major health, safety, and security problem. Employees needing help in dealing with such problems are encouraged to seek assistance through use of community resources, employee assistance programs or through our health insurance plan, as appropriate.

4. <u>As a condition of employment</u>, an employee must abide by the terms of the above policy and is required to notify SHORE UP! Inc. Personnel Management of any criminal drug status conviction for a violation occurring on or off agency premises while conducting agency business within five (5) days after the conviction.

_____ _____

Employee's Signature Date

SHORE UP! INC.
Helping People. Changing Lives.

Freddy L. Mitchell
Executive Director

## EMPLOYEE ETHICS POLICY
(Standard Clause)

As a condition of employment, all employees of SHORE UP! Inc. or its affiliates, whose job classification is Management Level or above, are required to sign this certificate indicating their understanding and acceptance of these standard clauses relating to their employment.

1. The employee will neither offer, nor promise his or her services for hire to any public or private agency, organization, institution, company, group or individual during the period of employment without prior notice to, and prior approval of the Executive Director of SHORE UP! Inc. This does not preclude negotiations with another organization for the purpose of obtaining another regular full-time or part-time job in the place of the SHORE UP!, Inc. position. However, this provision does prohibit the use of the employee's name, either orally or in writing, by or for another organization seeking to obtain some advantage, such as a contract, through the use of the employee's name, unless the Executive Director approves such a procedure in writing.
2. The employee will not perform professional services or consultation for any other organizations or governmental entity for payor pro bono (for public good) without written approval of the Executive Director.
3. The employee will neither disclose, discuss, nor make available the contents of any materials (proposals, policies, training materials, etc.) developed by or for SHORE UP!, Inc., for its own use or for its clients use, to representatives of any other organization (besides the organization for which the material was developed) for a period covering the employee's employment with SHORE UP I, Inc. and the succeeding twelve months. All work products developed by the employee for SHORE UP!, Inc. or its clients are the property of SHORE UP! Inc.
4. The employee, in accepting the position, releases SHORE UP! Inc. and its affiliates to use any photographs of the employee taken in the course of work for educational or promotional purposes.

I accept these provisions of employment and understand that violations of the above may result in action up to and including termination of employment, or that SHORE UP! Inc. may seek other legal or equitable remedies as it deems necessary.

Accepted: _____ Date: _____
Employee's signature

SHORT-TERM DISABILITY is afforded to every full-time employee that works at least 30 hours per week. When initial enrollment forms are completed, this insurance coverage takes effect after sixty (60) days of employment at SHORE UP! Inc. There is no cost to the employee for this insurance. Employees should contact the personnel office if any changes need to be made to your policy. The short-term disability insurance covers 60% of your weekly gross income for a period of thirteen weeks, if the employee does not have sick leave available to cover him/her during illness. When, or if, the employee has less than 15 days of sick leave available through SHORE UP!, they are encouraged to contact personnel management to begin the process of applying for short-term disability payments. Employees should be aware that benefit payments become effective on the eighth (8th) consecutive day of disability due to accident or sickness. All payments come directly from the insurance company, and employees are advised when checks are received by SHORE UP! Inc.

The employee basic life-benefit amount for group term-life insurance is 1½ times your annual salary for employees under age 65.

UnitedHealthcare®
Specialty Benefits™

# ENROLLMENT FORM - Group Life and Disability

*Group Life and Disability Insurance products provided by Unimerica Insurance Company or UnitedHealthcare Insurance Company*

**Use this form to apply for or to make changes to the applicable coverages listed below.**
**Late applicants are subject to Evidence of Insurability.**

**The following information is required to accurately enroll you and your dependents in the applicable coverage(s) requested. Missing information will delay enrollment processing.**

**Name**
**Address, including zip code**
**Social Security Number**
**Gender**
**Date of birth**
**Hire date (not needed if initial new case enrollment)**
**Class (if applicable)**
**Subgroup (if applicable)**
**Annual salary (required for salary based benefits)**
**Tobacco use (if benefits/rates are based on non-tobacco, tobacco use)**

**Supplemental Benefits:**
**Amount of current coverage**
**Amount of new coverage requested**
**Total amount of coverage after adding current and new coverage amounts**

**Dependent Benefits:**
**Dependent name and relationship to Employee**
**Dependent date of birth**
**Gender**
**Handicapped information (if applicable)**
**Student information (full-time, part-time, date or enrollment and name of each school)**

## A. EMPLOYEE INFORMATION

☐ Enroll ☐ Cancel ☐ Address Change ☐ Name Change ☐ Other Date

| Last Name First Name M.I. | Social Security Number | Gender ☐ M ☐ F | Date of Birth |
|---|---|---|---|
| Street Address / Apt No. / City / State / Zip Code | | | ☐ Single ☐ Married |
| Home Phone ( ) | Work Phone ( ) | Annual Salary | |
| Employer or Group Name / Division/Location / Subgroup Code | | Job Title | |

If applicable, have you or your dependent(s) used tobacco of any kind during the last twelve months? ☐ Yes ☐ No
If Yes, who? ☐ Employee ☐ Dependent Spouse ☐ Dependent Child

UnitedHealthcare®
Specialty Benefits™

## B. PRODUCT SELECTION – Application for (check all that apply):

Employee Hire Date: _____

**Basic Life and AD&D Insurance:**
☐ Basic Life Insurance ☐ Basic Accidental Death and Dismemberment (AD&D)

***Employee Supplemental Life and AD&D Insurance:*** **Increases may be subject to Evidence of Insurability**

☐ Employee Supplemental Life:
Current Amount of Coverage: $_____
☐ Increase coverage by: $_____
☐ Decrease coverage by: $_____
Total Amount of Coverage: $_____

☐ Employee Supplemental AD&D:
Current Amount of Coverage: $_____
☐ Increase coverage by: $_____
☐ Decrease coverage by: $_____
Total Amount of Coverage: $_____

**Beneficiary Designation:** Beneficiary information should be maintained by the Employer on a separate Beneficiary form.

**Basic Dependent Life and AD&D Insurance:**

☐ Basic Dependent Life Spouse: $ _____ amount
☐ Basic Dependent Life Child(ren): $_____ amount
☐ Basic Dependent AD&D Spouse: $ _____ amount
☐ Basic Dependent AD&D Child(ren): $ _____ amount

***Dependent Supplemental Life and AD&D Insurance:*** **Increases may be subject to Evidence of Insurability**

☐ Dependent Spouse Supplemental Life:
Current Amount of Coverage: $_____
☐ Increase coverage by: $_____
☐ Decrease coverage by: $_____
Total Amount of Coverage: $_____

☐ Dependent Spouse AD&D:
Current Amount of Coverage: $_____
☐ Increase coverage by: $_____
☐ Decrease coverage by: $_____
Total Amount of Coverage: $_____

☐ Dependent Child Supplemental Life:
Current Amount of Coverage: $_____
☐ Increase coverage by: $_____
☐ Decrease coverage by: $_____
Total Amount of Coverage: $_____

☐ Dependent Child AD&D:
Current Amount of Coverage: $_____
☐ Increase coverage by: $_____
☐ Decrease coverage by: $_____
Total Amount of Coverage: $_____

**Disability Insurance:**
☐ Short Term Disability (STD) ☐ Long Term Disability (LTD)

## C. INFORMATION FOR DEPENDENT COVERAGE (List all family members to be covered)

| Last name First Name M.I. | Date of Birth | Relationship | If child is over age 19, please indicate status and/or school | Gender | Check one |
|---|---|---|---|---|---|
| | | | ☐ Handicapped ☐ Student at | ☐ M ☐ F | ☐ Enroll ☐ Waive ☐ Cancel ☐ Change |
| | | | ☐ Handicapped ☐ Student at | ☐ M ☐ F | ☐ Enroll ☐ Waive ☐ Cancel ☐ Change |
| | | | ☐ Handicapped ☐ Student at | ☐ M ☐ F | ☐ Enroll ☐ Waive ☐ Cancel ☐ Change |
| | | | ☐ Handicapped ☐ Student at | ☐ M ☐ F | ☐ Enroll ☐ Waive ☐ Cancel ☐ Change |

## D. SIGNATURE (This form must be signed)

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

X _____ _____
Signature of Employee Date

## E. EMPLOYER USE ONLY

| ☐ Initial enrollment following Date of Hire ☐ Late Applicant | Employee Effective Date (mm/dd/yyyy) | Signed for Employer by | Group Number |
|---|---|---|---|
| | | | |

# Beneficiary Form
## Group Term Life Insurance

UnitedHealthcare
A UnitedHealth Group Company

Policy Holder: _____

Individual Covered Person: _____

SS#: _____

**Note:** This Beneficiary Designation cancels any prior beneficiary designation and shall be effective on the date received by the Company.

THE BENEFICIARY FOR THE POLICY SHALL BE:

| a) | Primary Beneficiary | Percentage | Relationship to Insured | Address |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| **b)** | **Contingent Beneficiary** | **Percentage** | **Relationship to Insured** | **Address** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

INSURED: _____

Signature: _____ Date: _____

**Employees' Pension system / Teacher's Pension System, Reformed Contributory Pension Benefit (established July 1, 2011)**

New Hires -- employed on or after 7/1/2011

| | **Approved Reforms - Effective 7/1/11** |
|---|---|
| Employee Contribution | 7% |
| Benefit Multiplier | 1.5% |
| Average Final Compensation | Calculate using highest 5 consecutive years |
| Full Service Retirement | Rule of 90<br>(sum of age and eligibility service must equal 90)<br>or<br>age 65 with 10 years eligibility service |
| Early Service Retirement | Age 60 and 15 years eligibility service |
| Vesting | 10 years eligibility service |
| Cost of Living Adjustment (COLA) | Compound COLA remains linked to CPI but capped at:<br><br>2.5% if assumed rate of return* for investments in prior year is achieved.<br><br>1% if investment target not met<br><br>(Applies to credit earned by current and new employees on or after 7/1/2011)<br>*currently 7.75% |

MARYLAND STATE RETIREMENT AGENCY
120 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202

# APPLICATION FOR MEMBERSHIP

**IMPORTANT: PLEASE PRINT CLEARLY AND READ THE INSTRUCTIONS FIRST.** | **FOR RETIREMENT USE ONLY** FORM 001 (REV. 3/10)

APPLICANT'S SOCIAL SECURITY NUMBER ___ - ___ - ____ GENDER (M or F) ____ DATE OF BIRTH ____ (Month) ____ (Day) ____ (Year)

APPLICANT'S NAME
First _____ Initial ____ Last _____

HOME ADDRESS
Number and Street _____
City _____ State ____ Zip Code _____ - ____

Home Phone Number ___ - ___ - ____

1. Have you ever been a member of the Maryland State Retirement and Pension System? ..... Yes ☐ No ☐
2. Are you presently receiving a retirement allowance from the Maryland State Retirement and Pension System? ..... Yes ☐ No ☐
3. Are you presently a member of another State or local retirement or pension system operated under the laws of Maryland or any political subdivision of Maryland? ..... Yes ☐ No ☐
   **IMPORTANT:** If yes, read carefully the transfer provisions on the back of this form and then initial here: _____.
4. Have you attached acceptable proof of birth date as described on the back of this form? ..... Yes ☐ No ☐

I certify that all statements made on this application are correct. I authorize any required deductions from my salary at the prescribed rate. And if I am presently a member of another State or local retirement or pension system, I have read and understand the transfer provisions.

_____ Complete Signature

_____ Date Signed

## RETIREMENT COORDINATOR COMPLETES THIS SECTION

A. IS THE APPLICANT A PERMANENT EMPLOYEE? ..... Yes ☐ No ☐
   If part-time, what percentage of time is the applicant employed? ..... _____ percent
B. When did applicant begin present continuous service? .....Month_____ Day_____ Year
C. What is the applicant's complete job classification or title?_____
D. What is the applicant's annual salary? $_____ What is the applicant's annual standard hours?_____
E. If applying for membership in the Law Enforcement Officers' Pension System, does the applicant meet the eligibility requirements? ..... Yes ☐ No ☐
F. Number of pay periods reported per year ..... _____

**INDICATE SYSTEM:** ☐ Teachers' Pension ☐ Employees' Pension ☐ Correctional Officers' Retirement ☐ State Police Retirement ☐ Law Enforcement Officers' Pension

EMPLOYING AGENCY CODE _____

# OF RETIREMENT CONTRIBUTIONS DEDUCTED PER YEAR ____

SYSTEM ____

FOR RETIREMENT USE ONLY
____ MO DAY YEAR
ENTRANCE DATE

_____ RETIREMENT COORDINATOR SIGNATURE DATE

_____ TELEPHONE #

# MARYLAND STATE RETIREMENT AGENCY

120 EAST BALTIMORE STREET
BALTIMORE, MARYLAND 21202-6700

## DESIGNATION OF BENEFICIARY

**IMPORTANT:** PLEASE RETURN COMPLETED FORM TO THE ADDRESS LISTED ABOVE. PRINT CLEARLY AND READ THE INSTRUCTIONS FIRST. FILL IN ALL SECTIONS. RETAIN A COPY FOR YOUR RECORDS.

FOR RETIREMENT USE ONLY FORM 4 (REV. 3/10)

APPLICANT'S SOCIAL SECURITY NUMBER ___ - ___ - ____

CHECK ONE: ☐ Working ☐ Vested ☐ Retired (If retiring, retirement date _____)

**IMPORTANT:** If you are retired under Option 2, 3, 5 or 6, **STOP**. You cannot use this form. You must complete a Form 66 to initiate any beneficiary changes.

APPLICANT'S NAME

First Initial Last

HOME ADDRESS

Number and Street

City State Zip Code

**PRIMARY BENEFICIARY(IES)** All money shall be paid in equal shares to the primary beneficiary(ies) who are living at the time of my death.

☐ Check if you used an additional Form 4 to name additional primary beneficiaries.

BENEFICIARY'S NAME RELATIONSHIP _____ Gender: ___ (M or F) Birthdate: ___ Month ___ Day ____ Year

First Initial Last

BENEFICIARY'S ADDRESS _____

BENEFICIARY'S NAME RELATIONSHIP _____ Gender: ___ (M or F) Birthdate: ___ Month ___ Day ____ Year

First Initial Last

BENEFICIARY'S ADDRESS _____

**CONTINGENT BENEFICIARY(IES)** If all primary beneficiaries die before me all money shall be paid in equal shares to the following person(s) who are living at the time of my death.

☐ Check if you used an additional Form 4 to name additional contingent beneficiaries.

BENEFICIARY'S NAME RELATIONSHIP _____ Gender: ___ (M or F) Birthdate: ___ Month ___ Day ____ Year

First Initial Last

BENEFICIARY'S ADDRESS _____

BENEFICIARY'S NAME RELATIONSHIP _____ Gender: ___ (M or F) Birthdate: ___ Month ___ Day ____ Year

First Initial Last

BENEFICIARY'S ADDRESS _____

**TO THE MARYLAND STATE RETIREMENT AGENCY**

I authorize the Maryland State Retirement Agency to pay the death benefit to my designated beneficiary or beneficiaries. I agree on behalf of my estate, heirs and assigns that the payment made by the agency will release the agency from any further obligation regarding this benefit. I direct the agency to pay the death benefit to my estate if I have not designated any beneficiary or if all of the primary and contingent beneficiaries I have named die before me. I understand that I may change beneficiaries at any time by filing a new Designation of Beneficiary form with the Maryland State Retirement Agency. Any new Designation of Beneficiary form I file will replace this form. I understand certain payment due to a minor shall be made only to the legal guardian of that minor. SIGN IN THE PRESENCE OF A NOTARY PUBLIC. (Form not valid unless notarized.)

**Signature** _____ **Date Signed** _____

State of _____ County of _____ (or City of Baltimore) On this _____ day of _____, 20 _____, before me, the undersigned officer, personally appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledged that (he/she) executed the same for the purposes therein contained. In witness whereof I hereunto set my hand and official seal.

{ Official Seal must be affixed }

Signature of Notary Public _____

Printed Name of Notary Public _____ My Commission Expires _____

FORM
# MW507

**Purpose.** Complete Form MW507 so that your employer can withhold the correct Maryland income tax from your pay. Consider completing a new Form MW507 each year and when your personal or financial situation changes.

**Basic Instructions.** Enter on line 1 below, the number of personal exemptions that you will be claiming on your tax return; however, if you wish to claim more exemptions, or if your adjusted gross income will be more than $100,000 if you are filing single or married filing separately ($150,000, if you are filing jointly or as head of household), you must complete the Personal Exemption Worksheet on page 2. Complete the Personal Exemption Worksheet on page 2 to further adjust your Maryland withholding based upon itemized deductions, and certain other expenses that exceed your standard deduction and are not being claimed at another job or by your spouse. However, you may claim fewer (or zero) exemptions.

**Additional withholding per pay period under agreement with employer.** If you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on line 2.

**Exemption from withholding.** You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. last year you did not owe any Maryland Income tax and had a right to a full refund of any tax withheld; AND

b. this year you do not expect to owe any Maryland income tax and expect to have a right to a full refund of all income tax withheld.

If you are eligible to claim this exemption, complete Line 3 and your employer will not withhold Maryland income tax from your wages.

Students and Seasonal Employees whose annual income is below the minimum filing requirements should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

**Certification of nonresidence in the State of Maryland.** Complete Line 4. This line is to be completed by residents of the District of Columbia, Pennsylvania, Virginia or West Virginia who are employed in Maryland and who do not maintain a place of abode in Maryland for 183 days or more.

Line 4 is **NOT** to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia, Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law. If you are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

Under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act, you may be exempt from Maryland income tax on your wages if (i) your spouse is a member of the armed forces present in Maryland in compliance with military orders; (ii) you are present in Maryland solely to be with your spouse; and (iii) you maintain your domicile in another state. If you claim exemption under the SCRA enter your state of domicile (legal residence) on Line 5; enter "EXEMPT" in the box to the right on Line 5; and attach a copy of your spousal military identification card to Form MW507. **Beginning 2011, you must also complete and attach Form MW507M.**

Duties and responsibilities of employer. Retain this certificate with your records. You are required to submit a copy of this certificate and accompanying attachments to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. you have any reason to believe this certificate is incorrect;
2. the employee claims more than 10 exemptions;
3. the employee claims an exemption from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week;
4. the employee claims an exemption from withholding on the basis of nonresidence; or
5. the employee claims an exemption from withholding under the Military Spouses Residency Relief Act.

Upon receipt of any exemption certificate (Form MW 507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the Comptroller, the employer must send any new certificate from the employee to the Comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 or 5 above, a new exemption certificate must be filed by February 15th of the following year.

**Duties and responsibilities of employee.** If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding exemption certificate in effect, the employee shall file a new withholding exemption certificate with the employer within 10 days after the change occurs.

FORM
# MW507

## Employee's Maryland Withholding Exemption Certificate

| Print full name | Social Security number |
|---|---|
| | |
| Street Address City, State, Zip | County of residence (or Baltimore City) |
| | |

☐ Single ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single Rate

1. Total number of exemptions you are claiming not to exceed line f in Personal Exemption Worksheet on page 2 ..... 1.

2. Additional withholding per pay period under agreement with employer ..... 2. $

3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions above and check boxes that apply.
   ☐ a. Last year I did not owe any Maryland Income tax and had a right to a full refund of all Income tax withheld and
   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld.
   (This includes seasonal and student employees whose annual income will be below the minimum filing requirements).
   If both a and b apply, enter year applicable _____ (year effective) Enter "EXEMPT" here..... 3.

4. I claim exemption from withholding because I am domiciled in one of the following states. Check state that applies.
   ☐ District of Columbia ☐ Pennsylvania ☐ Virginia ☐ West Virginia
   I further certify that I do not maintain a place of abode in Maryland as described in the instructions above. Enter "EXEMPT" here... 4.

5. I certify that I am a legal resident of the state of _____ and am not subject to Maryland withholding because I meet the requirements set forth under the Servicemembers Civil Relief Act, as amended by the Military Spouses Residency Relief Act.
   Enter "EXEMPT" here ..... 5.

Under the **penalty of perjury**, I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3, 4 or 5, whichever applies.

| Employee's signature | Date |
|---|---|
| | |
| Employer's Name and address including zip code (For employer use only) | Federal employer identification number |
| | |

FORM
**MW507**

## Personal Exemptions Worksheet

### Line 1

**a**. Multiply the number of your personal exemptions by the value of each exemption from the table below. (Generally the value of your exemption will be $3,200; however, if your federal adjusted gross income is expected to be over $100,000, the value of your exemption may be reduced. **Do not claim any personal exemptions that you are currently claiming at another job, or any exemptions being claimed by your spouse.** To qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year. **NOTE:** Dependent taxpayers may not claim themselves as an exemption. . . . . a. _____

**b.** Multiply the number of additional exemptions you are claiming for dependents who are 65 years of age or older by the value of each exemption from the table below. . . . . b. _____

**c.** Enter the estimated amount of your itemized deductions (excluding state and local income taxes) that exceed the amount of your standard deduction, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. Do not claim any additional amounts you are currently claiming at another job; or any amounts being claimed by your spouse. **NOTE:** Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000. . . . . c. _____

**d.** Enter $1,000 for additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind. . . . . d. _____

**e.** Add total of lines **a** through **d**. . . . . e. _____

**f.** Divide the amount on line e by $3,200. **Drop any fraction. Do not round up.** This is the **maximum** number of exemptions you may claim for withholding tax purposes. ..... . . . . f. _____

| **If Your federal AGI is** | | **If you will file your tax return** | |
|---|---|---|---|
| | | Single or Married Filing Separately **Your Exemption is** | Joint, Head of Household or Qualifying Widow(er) **Your Exemption is** |
| **$100,000 or less** | | **$3,200** | **$3,200** |
| **Over** | **But not over** | | |
| **$100,000** | **$125,000** | **$2,400** | **$3,200** |
| **$125,000** | **$150,000** | **$1,800** | **$3,200** |
| **$150,000** | **$175,000** | **$1,200** | **$2,400** |
| **$175,000** | **$200,000** | **$1,200** | **$1,800** |
| **$200,000** | **$250,000** | **$600** | **$1,200** |
| **In excess of $250,000** | | **$600** | **$600** |

## FEDERAL PRIVACY ACT INFORMATION

Social Security numbers must be included. The mandatory disclosure of your Social Security number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws administered by the person having statutory right to obtain it.

SEXUAL HARASSMENT POLICY

EMPLOYEE CERTIFICATION & DECLARATION

**POLICY**

SHORE UP! Inc. does not condone any activity or conduct that may be construed as sexual harassment. Any allegations of sexual harassment must and will be promptly and vigorously investigated to resolve the complaint.

**DEFINITIONS**

Harassment on the basis of sex is a violation of Section 703 of Title VII. Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct oj a sexual nature constitute sexual harassment when:

1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, or

2. Submission to or request of such conduct by an individual is used as the basis for employment decisions affecting such individual, or

3. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

**PROCEDURES**

1. All employees will be informed and educated on the policy against sexual harassment - written copy to each.

2. Complaints of sexual harassment are made to supervisor unless supervisor is the offender, then to the Administrator or Personnel Management.

3. Supervisor or designee will investigate allegations promptly and thoroughly, and take appropriate disciplinary actions, if warranted.

**CERTIFICATION AND DECLARATION**

I have been provided a written copy of SHORE UP! Inc.'s policy on Sexual Harassment, I am aware that this policy prohibits any conduct or activity that may be viewed as sexual harassment and that violation of this policy is cause for disciplinary action.

Employee's Signature _____ Date _____

America's Premier Dental Insurer
1220 B East Joppa Road, Suite 421, Towson, MD 21286

TYPE PROGRAM

☐ ConcordiaPLUS

☐ New Enrollment
☐ Change (specify)
- ☐ Add Dependent
- ☐ New Address
- ☐ Change of Employee Status
- ☐ Cancel Coverage
- ☐ Cancel Contract
- ☐ Reinstate

| EFFECTIVE DATE |
|---|
| |

| ENR SOURCE |
|---|
| |

| GROUP NUMBER | SUB GROUP |
|---|---|
| | |

NOTE: Incomplete information on this form will delay your enrollment. Please print clearly.

| Social Security Number | Employee Name (Last, First, Middle Initial) | | Date of Birth |
|---|---|---|---|
| Home Address | | | Home Phone ( ) |
| City | State | Zip Code | Work Phone ( ) |

Date of Marriage / /
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

| Previous Dental Insurance | Payroll Location |
|---|---|
| Employer Name | Employer Address |

Date Hired / /
Employee Number
Employee Type: ☐ Current ☐ New ☐ Rehire ☐ Open Enrollment ☐ COBRA

Employee Status: ☐ Hourly ☐ Salaried (Union Represented) ☐ Management ☐ Salaried (Not Union Represented) ☐ COBRA ☐ Retiree

## PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT.

| Last Name | First Name | MI | Sex | Date of Birth | Social Security | ConcordiaPLUS, Primary Care Dentist No. (See listing) |
|---|---|---|---|---|---|---|
| Self | | | | / / | - - | |
| Dependent | | | | / / | - - | |
| Dependent | | | | / / | - - | |
| Dependent | | | | / / | - - | |
| Dependent | | | | / / | - - | |

IF ANY OF THE CHILDREN LISTED ABOVE ARE HANDICAPPED (H), FULL-TIME STUDENT(S) AGE 19 AND OVER, PLEASE MARK AN "H", OR "S" BESIDE THE DEPENDENT'S NAME.

Important: Do you or your dependent(s) have other Group Dental Coverage? ☐ Yes ☐ No
**If your answer to the above question is yes, please complete the following information.**

| Name of Insured | Insurance Company | Policy Number |
|---|---|---|
| Name of Insured | Insurance Company | Policy Number |
| Name of Insured | Insurance Company | Policy Number |

*Prior to signing I have read the reverse side.*

Employee's Signature _____ Date: _____

Employer's Signature _____ Phone No: _____ Date: _____

MD5000DHMO (12/98)

White Copy - United Concordia • Yellow Copy - Employer • Pink Copy - Employee

# Enrollment Application and Change Form – Choice/Open Access

**PLEASE READ INSTRUCTIONS ON REVERSE SIDE.**

☐ New Coverage ☐ Request for Change

UnitedHealthcare®
A UnitedHealth Group Company

## 1 EMPLOYEE INFORMATION

| Last Name | First Name | MI | Sex ☐ Male ☐ Female | Date of Birth | Social Security Number | Marital Status ☐ Single ☐ Married |
|---|---|---|---|---|---|---|
| Home Address | City | | | State | Zip Code | Home Phone Number ( ) |
| Employer Name | Division/Location | ☐ FT ☐ PT | ☐ Union ☐ Nonunion | ☐ Hourly ☐ Salary | ☐ Active ☐ Retired (Date ) | Work Phone Number ( ) |

## 3 WHO SHOULD BE COVERED

- ☐ Employee Only
- ☐ Employee Plus Spouse
- ☐ Employee Plus One Dependent
- ☐ Employee Plus Child(ren)
- ☐ Employee Plus Family

## 2 WAIVER OF COVERAGE

- ☐ I decline coverage for myself
- ☐ I decline coverage for my dependents

*Reason:* ☐ covered under another plan ☐ Other: _____ (see sections 6&7)

***Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date.***

## 4 TYPE OF CHANGE

- ☐ Add Spouse/Child (complete Sec. 5)
- ☐ Terminate Spouse/Child (complete Sec. 5)
- ☐ Address (enter above)
- ☐ Name Change (complete Sec. 5)
- ☐ Terminate All Coverage – Reason _____
- ☐ Reinstatement – Reason _____
- ☐ **Surviving Spouse – Former Employee SSN** _____
- ☐ **COBRA Continuee – Former Employee SSN** _____
- ☐ Other _____

## 5 COVERAGE INFORMATION

| (A) Add (T) Term (C) Chg | Last Name | First Name | MI | Zip Code | Date of Birth (MM/DD/YY) | Sex | Other Insurance | Disabled | Full-Time Student Over 19? |
|---|---|---|---|---|---|---|---|---|---|
| | Employee | | | | | | | | |
| | Spouse | | | | | ☐M ☐F | ☐Y ☐N | | |
| | Child 1 | | | | | ☐M ☐F | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| | Child 2 | | | | | ☐M ☐F | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |
| | Child 3 | | | | | ☐M ☐F | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N |

## 6 OTHER INSURANCE

On the day your coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another United HealthCare plan, Medicare or Medicaid? ☐Y ☐N

Is another person legally responsible for coverage for your children? ☐Y ☐N

If you answered yes to either of the questions above, please complete the following:

| Person's Name with Other Health Plan | | Social Security Number |
|---|---|---|
| Date of Birth | Sex | Other Company's Name and Phone Number |
| Other Company's Policy Number and Effective Date | | |
| Medicare Number | Part A Effective Date | Part B Effective Date |

## 7 AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give United HealthCare and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the Insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

If my employees plan is a contributory plan, I direct my employer to deduct the amount of any required contribution from my pay. I can cancel this direction in writing at any time.

**NOTICE OF ENROLLMENT RIGHTS**

**I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.**

Health insurance or medical services benefits provided or administered by United HealthCare Insurance Company, Minneapolis, MN.

X Signature _____ Date _____

## 8 TO BE COMPLETED BY EMPLOYER

| Date of Hire | Date Submitted | Health/Change Eff. Date | Policy Number | GRP/SUBGRP/BNFT GRP | Plan Variation/Sub | Reporting Code/Branch | Employer Signature |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

# Form W-4 (2011)

**Purpose.** Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

**Exemption from withholding.** If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2011 expires February 16, 2012. See Pub. 505, Tax Withholding and Estimated Tax.

**Note.** If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

**Basic instructions.** If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

**Head of household.** Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

**Tax credits.** You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 919, How Do I Adjust My Tax Withholding, for information on converting your other credits into withholding allowances.

**Nonwage income.** If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 919 to find out if you should adjust your withholding on Form W-4 or W-4P.

**Two earners or multiple jobs.** If you have a working spouse or 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-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 919 for details.

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

**Check your withholding.** After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2011. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

## Personal Allowances Worksheet (Keep for your records.)

| | | |
|---|---|---|
| **A** | Enter "1" for **yourself** if no one else can claim you as a dependent | **A** |
| **B** | Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less. | **B** |
| **C** | Enter "1" for your **spouse.** But, you may 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 number of **dependents** (other than your spouse or yourself) you will claim on your tax return | **D** |
| **E** | Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) | **E** |
| **F** | Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.) | **F** |
| **G** | **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children | **G** |
| **H** | Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► | **H** |

**For accuracy, complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Cut here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

## Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

**2011**

| | | |
|---|---|---|
| **1** Type or print your first name and middle initial. / Last name | | **2 Your social security number** |
| Home address (number and street or rural route) | **3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box. | |
| City or town, state, and ZIP code | **4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐ | |
| **5** Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) | | **5** |
| **6** Additional amount, if any, you want withheld from each paycheck | | **6** $ |
| **7** I claim exemption from withholding for 2011, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ► | | **7** |

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

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

| | | | |
|---|---|---|---|
| **8** Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.) | **9** Office code (optional) | **10** Employer identification number (EIN) | |

## Deductions and Adjustments Worksheet

**Note.** Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

| | | | |
|---|---|---|---|
| 1 | Enter an estimate of your 2011 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions | 1 | $ |
| 2 | Enter: { $11,600 if married filing jointly or qualifying widow(er); $8,500 if head of household; $5,800 if single or married filing separately } | 2 | $ |
| 3 | **Subtract** line 2 from line 1. If zero or less, enter "-0-" | 3 | $ |
| 4 | Enter an estimate of your 2011 adjustments to income and any additional standard deduction (see Pub. 919) | 4 | $ |
| 5 | **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2011 Form W-4 Worksheet* in Pub. 919.) | 5 | $ |
| 6 | Enter an estimate of your 2011 nonwage income (such as dividends or interest) | 6 | $ |
| 7 | **Subtract** line 6 from line 5. If zero or less, enter "-0-" | 7 | $ |
| 8 | **Divide** the amount on line 7 by $3,700 and enter the result here. Drop any fraction | 8 | |
| 9 | Enter the number from the **Personal Allowances Worksheet,** line H, page 1 | 9 | |
| 10 | **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 | 10 | |

## Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

**Note.** Use this worksheet *only* if the instructions under line H on page 1 direct you here.

| | | | |
|---|---|---|---|
| 1 | Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) | 1 | |
| 2 | Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" | 2 | |
| 3 | If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet | 3 | |

**Note.** If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

| | | | | | |
|---|---|---|---|---|---|
| 4 | Enter the number from line 2 of this worksheet | 4 | | | |
| 5 | Enter the number from line 1 of this worksheet | 5 | | | |
| 6 | **Subtract** line 5 from line 4 | | | 6 | |
| 7 | Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here | | | 7 | $ |
| 8 | **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed | | | 8 | $ |
| 9 | Divide line 8 by the number of pay periods remaining in 2011. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2010. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck | | | 9 | $ |

### Table 1

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **LOWEST** paying job are— | Enter on line 2 above | If wages from **LOWEST** paying job are— | Enter on line 2 above |
| $0 - $5,000 | 0 | $0 - $8,000 | 0 |
| 5,001 - 12,000 | 1 | 8,001 - 15,000 | 1 |
| 12,001 - 22,000 | 2 | 15,001 - 25,000 | 2 |
| 22,001 - 25,000 | 3 | 25,001 - 30,000 | 3 |
| 25,001 - 30,000 | 4 | 30,001 - 40,000 | 4 |
| 30,001 - 40,000 | 5 | 40,001 - 50,000 | 5 |
| 40,001 - 48,000 | 6 | 50,001 - 65,000 | 6 |
| 48,001 - 55,000 | 7 | 65,001 - 80,000 | 7 |
| 55,001 - 65,000 | 8 | 80,001 - 95,000 | 8 |
| 65,001 - 72,000 | 9 | 95,001 -120,000 | 9 |
| 72,001 - 85,000 | 10 | 120,001 and over | 10 |
| 85,001 - 97,000 | 11 | | |
| 97,001 -110,000 | 12 | | |
| 110,001 -120,000 | 13 | | |
| 120,001 -135,000 | 14 | | |
| 135,001 and over | 15 | | |

### Table 2

| Married Filing Jointly | | All Others | |
|---|---|---|---|
| If wages from **HIGHEST** paying job are— | Enter on line 7 above | If wages from **HIGHEST** paying job are— | Enter on line 7 above |
| $0 - $65,000 | $560 | $0 - $35,000 | $560 |
| 65,001 - 125,000 | 930 | 35,001 - 90,000 | 930 |
| 125,001 - 185,000 | 1,040 | 90,001 - 165,000 | 1,040 |
| 185,001 - 335,000 | 1,220 | 165,001 - 370,000 | 1,220 |
| 335,001 and over | 1,300 | 370,001 and over | 1,300 |

**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 who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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