New Employee Information Form/ Status Change Form

Jackson County ILLINOIS

** Updated January 2026*

If filling out for Status Change, please complete all appropriate sections

The Basics

Department:			**Hire Date:**		
Job Title:			**Rehire?**	**Yes**	**No**
Job Description:	**Please attach a current copy of employees job description**		**When? Dates/Years**		
Employee Name:			**FMLA Start Date:**		
Address:			**Marital Status (circle one):**	Married	Single
Phone:				Divorced	Widowed
Work Email:					
Preferred PayStub Email:					
Social Security #:		**Date of Birth:**			

Payroll Information

Status: *(circle one)*	FT	PT	Temp			
	Seasonal	Intern	PRN			
Union: *(circle one)*	AFSCME Courthouse	AFSCME Circuit Clerk	AFSCME Ambulance	FOP	Laborers' Local (Health Dept)	N/A

Pay Type: (circle one)	Hourly	Salary	
Rate:	$	$	
Hourly/Salary GL#:			
	Fund	Dept	Line Item
Overtime GL #:			
	Fund	Dept	Line Item

If multiple GL#'s are required, please attach a separate piece of paper

Time Accrual: (cirlce all that apply)	Personal	Vacation	Sick	
	Comp	Overtime		

EEOC: *(circle one)*	Officials & Administrators	Professionals	Technicians	Protective Service
	Para-Professional	Administrative Support	Skilled Craft	Service & Maintenance
Functions: *(circle one)*	General Control	Streets & Highways	Public Welfare	Police Protection
	Natural Resources	Parks & Recreation	Hospitals & Sanitoriums	Health
	Employment Security	Sanitation & Sewage	Utilities & Transportation	Corrections
	Community Development	Housing	Other	

Status Change

Status Change: *(circle one)*	PT to FT	Other *(please describe)* :		
	FT to PT	N/A	**Effective Date of Change:**	

If status change is to FT, please fill in the health insurance section below

Health Insurance

All Health Insurance forms must be turned in to the County Board office no later than 2 weeks from date of hire to be eligible for insurance in current year.

Has Health Insurance been offered?			
Yes	No	Decline*	Not Eligible

Has Dental/Vision Insurance been offered?			
Yes	No	Decline	Not Eligible

If declining Health Insurance, please sign the HOPE form A notating the decline

Plan Chosen: *(circle one)*				
HOPE 4000 w/HSA	HOPE 1000	HRP	Dental/Vision Only	None

Flex Account?	Yes	No	Not eligible
HSA Account?	Yes	No	Not eligible

Insurance will take effect the 1st day of the month following the hire date (if employee is eligible).

Final Forms

IMRF/SLEP Complete?	IMRF	SLEP	n/a
Direct Deposit Complete?	Yes	No	
Federal/State W-4 Complete?	Yes	No	
Employee Emergency Contact?	Yes	No	

Federal I-9 Complete with copies of documents provided?	Yes	No	
Employee Handbook?	Yes	No	Other Department
Union Card?	Yes	No	n/a
Voluntary Self-Identification of Disability?	Yes	No	

Department Head Signature: _____ **Date:** _____

Please return a fully completed copy of this form along with ALL completed new hire forms to the County Board Office

Office Use Only		
1095-C information updated in HR	Yes	No
Paperwork emailed to Payroll Office	Yes	No
Employee added to NeoGov Training	Yes	No

Authorization for Direct Deposit - Employee Form

This authorizes _____ (the "Company") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method, to my (our) account(s) indicated below and to other accounts I (we) identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries.

Note: Enter your company name in the blank space above.

Account #1

Account #1 Type (check one): ☐ Checking ☐ Savings

_____
Employee Bank Name

_____ _____
Bank Routing # (ABA#) Account #

_____
Percentage or Dollar Amount to be Deposited to This Account

Account #2 (remainder to be deposited to this account)

Account #2 Type (check one): ☐ Checking ☐ Savings

_____
Employee Bank Name

_____ _____
Bank Routing # (ABA#) Account #

Please attach a voided check for each account here.

This authorization will be in effect until the Company receives a written termination notice from myself and has a reasonable opportunity to act on it.

_____
Signature

_____
Printed Name

_____ _____
Employee ID # Date

IMPORTANT: This document must be signed by employees requesting automatic deposit of paychecks and retained on file by the employer. Do not send this form to Intuit. Employees must attach a voided check for each of their accounts to help verify their account numbers and bank routing numbers.

Employee: Please fill out and return to your employer. **Employer: Please save for your files only.**

Ver. 041708 DD

Employee Emergency Contact Form

Employee Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

In Case of Emergency Please Contact:

Primary Contact Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Relationship: _____

Secondary Contact Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Relationship: _____

☐ **I authorize my employer to contact these individuals in the case of an emergency.**

☐ **I decline giving my employer emergency contact information.**

Employee Signature: _____

Date: _____ Department: _____

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.

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

Illinois Department of Revenue

Form IL-W-4

Employee's and other Payee's Illinois Withholding Allowance Certificate and Instructions

Note: These instructions are written for employees to address withholding from wages. However, this form can also be completed and submitted to a payor if an agreement was made to voluntarily withhold Illinois Income tax from other (non-wage) Illinois income.

Who must complete Form IL-W-4?

If you are an employee, you must complete this form so your employer can withhold the correct amount of Illinois Income Tax from your pay. The amount withheld from your pay depends, in part, on the number of allowances you claim on this form.

Even if you claimed exemption from withholding on your federal Form W-4, U.S. Employee's Withholding Allowance Certificate, because you do not expect to owe any federal income tax, you may be required to have Illinois Income Tax withheld from your pay (see Publication 130, Who is Required to Withhold Illinois Income Tax). If you are claiming exempt status from Illinois withholding, you must check the exempt status box on Form IL-W-4 and sign and date the certificate. Do not complete Lines 1 through 3.

If you are a resident of a Iowa, Kentucky, Michigan, or Wisconsin, or a military spouse, see Form W-5-NR, Employee's Statement of Nonresidence in Illinois, to determine if you are exempt.

If you are an Illinois resident who works for an employer in a non-reciprocal state but you work from home or in locations in Illinois for more than 30 working days, you may need to adjust your withholding or begin making estimated payments. For additional information, go to **tax.illinois.gov.**

Note If you do not file a completed Form IL-W-4 with your employer, if you fail to sign the form or to include all necessary information, or if you alter the form, your employer must withhold Illinois Income Tax on the entire amount of your compensation, without allowing any exemptions.

When must I submit this form?

You should complete this form and give it to your employer on or before the date you start work. You must submit Form IL-W-4 when Illinois Income Tax is required to be withheld from compensation that you receive as an employee. You may file a new Form IL-W-4 any time your withholding allowances increase. If the number of your claimed allowances decreases, you **must** file a new Form IL-W-4 within 10 days. However, the death of a spouse or a dependent does not affect your withholding allowances until the next tax year.

When does my Form IL-W-4 take effect?

If you do not already have a Form IL-W-4 on file with your employer, this form will be effective for the first payment of compensation made to you after this form is filed. If you already have a Form IL-W-4 on file with this employer, your employer may allow any change you file on this form to become effective immediately, but is not required by law to change your withholding until the first payment of compensation is made to you after the first day of the next calendar quarter (that is, January 1, April 1, July 1, or October 1) that falls at least 30 days after the date you file the change with your employer.

Example: If you have a baby and file a new Form IL-W-4 with your employer to claim an additional allowance for the baby, your employer may immediately change the withholding for all future payments of compensation. However, if you file the new form on September 1, your employer does not have to change your withholding until the first payment of compensation is made to you after October 1. If you file the new form on September 2, your employer does not have to change your withholding until the first payment of compensation made to you after December 31.

How long is Form IL-W-4 valid?

Your Form IL-W-4 remains valid until a new form you have submitted takes effect or until your employer is required by the Department to disregard it. Your employer is required to disregard your Form IL-W-4 if

- you claim total exemption from Illinois Income Tax withholding, but you have not filed a federal Form W-4 claiming total exemption, or
- the Internal Revenue Service (IRS) has instructed your employer to disregard your federal Form W-4.

What is an "exemption"?

An "exemption" is a dollar amount on which you do not have to pay Illinois Income Tax that you may claim on your Illinois Income tax return.

What is an "allowance"?

The dollar amount that is exempt from Illinois Income Tax is based on the number of allowances you claim on this form. As an employee, you receive one allowance unless you are claimed as a dependent on another person's tax return (*e.g.,* your parents claim you as a dependent on their tax return). If you are married, you may claim additional allowances for your spouse and any dependents that you are entitled to claim for federal income tax purposes. You also will receive additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind.

Note: For tax years beginning on or after January 1, 2017, the personal exemption allowance, and additional allowances if you or your spouse are age 65 or older, or if you or your spouse are legally blind, may **not** be claimed on your Form IL-1040 if your adjusted gross income for the taxable year exceeds $500,000 for returns with a federal filing status of married filing jointly, or $250,000 for all other returns. You may complete a new Form IL-W-4 to update your exemption amounts and increase your Illinois withholding.

How do I figure the correct number of allowances?

Complete the worksheet on the back of this page to figure the correct number of allowances you are entitled to claim. Give your completed Form IL-W-4 to your employer. Keep the worksheet for your records.

Note If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

How do I avoid underpaying my tax and owing a penalty?

You can avoid underpayment by reducing the number of allowances or requesting that your employer withhold an additional amount from your pay. Even if your withholding covers the tax you owe on your wages, if you have non-wage income that is taxable, such as interest on a bank account or dividends on an investment, you may have additional tax liability. If you owe more than $1,000 tax at the end of the year, you may owe a late-payment penalty or will be required to make estimated tax payments. For additional information on penalties see Publication 103, Uniform Penalties and Interest. Visit our website at **tax.illinois.gov** to obtain a copy.

Where do I get help?

- Visit our website at **tax.illinois.gov**
- Call our Taxpayer Assistance Division at **1 800 732-8866** or **217 782-3336**
- Call our TDD (telecommunications device for the deaf) at **1 800 544-5304**
- Write to
  ILLINOIS DEPARTMENT OF REVENUE
  PO BOX 19044
  SPRINGFIELD IL 62794-9044

Illinois Withholding Allowance Worksheet

General Information

Use this worksheet as a guide to figure your total withholding allowances you may enter on your Form IL-W-4.

Complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions Worksheet for federal Form W-4.

If you have more than one job or your spouse works, your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Enter the total number of boxes you checked. **1** _____

2 Enter the number of dependents (other than you or your spouse) you will claim on your tax return. **2** _____

3 Add Lines 1 and 2. Enter the result. This is the total number of basic personal allowances to which you are **entitled**. You are not required to claim these allowances. The number of basic personal allowances that you choose to claim will determine how much money is withheld from your pay. See Line 4 for more information. **3** _____

4 Enter the total number of basic personal allowances you choose to claim on this line and Line 1 of Form IL-W-4 below. This number may not exceed the amount on Line 3 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. **4** _____

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Enter the total number of boxes you checked. **5** _____

6 Enter any amount that you reported on Line 4 of the Deductions Worksheet for federal Form W-4 plus any additional Illinois subtractions or deductions. **6** _____

7 Divide Line 6 by 1,000. Round to the nearest whole number. Enter the result on Line 7. **7** _____

8 Add Lines 5 and 7. Enter the result. This is the total number of additional allowances to which you are **entitled**. You are not required to claim these allowances. The number of additional allowances that you choose to claim will determine how much money is withheld from your pay. **8** _____

9 Enter the total number of additional allowances you elect to claim on Line 2 of Form IL-W-4, below. This number may not exceed the amount on Line 8 above, however you can claim as few as zero. Entering lower numbers here will result in more money being withheld(deducted) from your pay. **9** _____

IMPORTANT: If you want to have additional amounts withheld from your pay, you may enter a dollar amount on Line 3 of Form IL-W-4 below. This amount will be deducted from your pay in addition to the amounts that are withheld as a result of the allowances you have claimed.

✂ — — — — — — — — Cut here and give the certificate to your employer. Keep the top portion for your records. — — — — — — — — ✂

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security number

Name

Street address

City State ZIP

Check the box if you are exempt from federal and Illinois Income Tax withholding and sign and date the certificate. ☐

1 Enter the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). **1** _____

2 Enter the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). **2** _____

3 Enter the additional amount you want withheld (deducted) from each pay. **3** _____

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

Your signature Date

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

Printed by the authority of the State of Illinois - web only,1 copy.

IL-W-4 (R-7/23)

This form is authorized under the Illinois Income Tax Act. Disclosure of this information is required. Failure to provide information may result in this form not being processed and may result in a penalty.

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.

NOTICE OF ENROLLMENT IN IMRF

IMRF Form 6.10 (Rev. 07/06)

Please print or type — Use Black Ink.
Please do not use a highlighter anywhere on the form.

MEMBER INFORMATION *(to be completed by member - please print or type)*

1. Last Name | First | Middle Initial | Jr., Sr., II, etc.

2. Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

3. Mailing Address

City | State | Zip + 4 | County

4. Home Telephone No.
( )

5. Birth Date: month/day/year

TAPE A COPY OF SOCIAL SECURITY CARD IN THIS SPACE

If a copy of the Social Security card is not attached, IMRF will use the Social Security number entered on this form. Any IRS penalties that result from an incorrect Social Security number will be the responsibility of the IMRF employer. **(Do not staple card—use tape and please stay within this border.)**

6. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

7. Gender ☐ Female ☐ Male

8. Are you currently participating or have you previously participated in IMRF or any other Illinois Public Pension systems?
☐ No ☐ Yes *[please check the box(es) to identify the pension system(s)]*

☐ IMRF (If indicating IMRF, are you currently collecting a pension from IMRF?) ☐ Yes ☐ No
☐ Chicago Public School Teachers' ☐ Cook County Annuity & Benefit Fund ☐ General Assembly Retirement System
☐ Judges' Retirement System ☐ Laborers' Annuity & Benefit Fund ☐ Cook County Forest Preserve Annuity & Benefit
☐ Metro Water Reclaim. Retirement System ☐ Municipal Employees Annuity & Benefit Fund ☐ Park Employees' Annuity & Benefit Fund
☐ State Universities Retirement System ☐ State Employees' Retirement System ☐ State Teachers' Retirement System

I certify this information is correct to the best of my knowledge and belief.

Employee signature *(write; do not print or type)*
X

Date

EMPLOYMENT INFORMATION - ALL FIELDS MUST BE COMPLETED *(to be completed by employer — please print or type)*

9. Employer Name

10. Employer IMRF I.D. Number

11. Position Information

Date employed mo day yr	Participation date* mo day yr	Employee will participate in:	(SLEP ONLY: CIRCLE ONE)	Position Title(s)
_____	_____	☐ Regular ☐ ECO	☐ SLEP (FT / PT)	_____
_____	_____	☐ Regular ☐ ECO	☐ SLEP (FT / PT)	_____

***If date employed is earlier than participation date, explain in detail** why the member was not enrolled immediately. The Illinois Pension Code does not recognize "probationary," "temporary," or "trial work period." Refer to Section 3 of the Authorized Agents Manual for details on participation requirements. _____

12. Will employee work in a seasonal position? ..... ☐ No ☐ Yes *OR*
Is employee an elected official who will be paid irregularly? ..... ☐ No ☐ Yes

If employee will hold a seasonal position and the seasonal employer is **not** a school district, park district, or recreation association, *OR* if employee is an elected official who will be paid irregularly, check the months the employee will **not** be paid:

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

13. Is employee:
A. Police chief eligible for transfer into IMRF for SLEP coverage?
☐ No ☐ Yes *(attach Form 6.22)*
B. Performing police duties? ..... ☐ No ☐ Yes
C. Performing fire protection duties? ..... ☐ No ☐ Yes
D. Performing teacher aide duties? ..... ☐ No ☐ Yes
(see instructions for examples)
E. City hospital worker?
☐ No ☐ Yes *(attach Form 6.21)*

14. Elected official or appointed to elected office?
☐ No ☐ Yes *(attach Form 6.21)*

15. For County employers only: Has member elected to participate in the Elected County Offical (ECO) plan?
☐ No ☐ Yes *(attach Form 6.21B)*

16. For SLEP employers only: Was SLEP member appointed by:
☐ Sheriff ☐ Merit Commission

I certify this information is correct to the best of my knowledge and belief, and that the person named above is employed in a position which qualifies him or her for membership in IMRF with the above employer.

Authorized Agent signature (write; do not print or type)
X

Date

Illinois Municipal Retirement Fund
2211 York Road, Suite 500, Oak Brook Illinois 60523-2337
Service Representatives 1-800-ASK-IMRF (1-800-275-4673)
www.imrf.org

Memorandum

Date: January 1, 2024

To: Jackson County Employees, Elected Officials and Department Heads

From: Jennifer Huson, County Administrator

Re: New Employee Health Insurance Forms

The County currently offers three health insurance plans: ***Hope 1000 Traditional Major Medical***, ***Hope 4000 QHDHP***, and ***HRP Health Reimbursement Plan***. The County also offers a ***Dental/Vision Plan***. Employees may contact the County Board office with any enrollment questions.

Forms Required

***All forms for enrollment are located in this New Hire Packet, on the Jackson County Website under *Community/Employment/Employee Resources*, or in the County Board Office.**

ALL FULL-TIME EMPLOYEES must fill out **Form A** *and note if they are* ***Accepting*** *a plan or are* ***Declining*** *all insurance*. If the employee will be ***accepting*** an insurance plan, they **MUST** then fill out **Forms B & C** and return them to the County Board Office no later than ***two weeks from their hire date.*** Family members may not be enrolled in a Health and/or Dental/Vision plan unless the employee is enrolled as well.

Failure to turn in health insurance forms by the date mentioned above will result in the Employee having to wait for Open Enrollment in October which will then take effect January 1st of the following year.

Health Savings Account

With the Hope 4000 plan, non-AFSCME Courthouse employees will receive $2,500 from the County (***this amount will be pro-rated depending on the month of hire***) and can add up to $1,650 (Individual) or $5,800 (Family) through **per-pay** payroll deductions. The HSA form will need to be completed by the employee. This form is located in this New Hire Packet, on the Jackson County Website under ***Community/Employment/Employee Resources***, or in the County Board Office**.**

The employee will also need to follow the **HSA Central Online Account Opening Instructions *EXPLICITLY***. This document is available on the Jackson County Website under ***Community/Employment/Employee Resources*** or in the County Board office.

Flexible Spending Account

With the HOPE 1000 plan, employees are eligible for this type of account. This is ***optional***, but if the employee wants to enroll in this account, the FSA agreement form will need to be filled out. This document is available in this New Hire packet, on the Jackson County Website under ***Community/Employment/Employee Resources***, or in the County Board Office.

If anyone wishes to have a summary of any of the plans offered, employee costs, or Preferred Providers list, they may visit the Jackson County Website under ***Community/Employment/Employee Resources*** *or contact the County Board Office.*

Should you have any additional questions or concerns please contact the County Board Office at 618-687-7240.

HOPE TRUST®
Health Options for Public Entities

Employer Record of Enrollment Offer

EMPLOYER SHOULD RETAIN COMPLETED FORM FOR RECORDS

ALREADY ENROLLED (NO CHANGES)

I am already enrolled along with any of my selected dependents (if applicable) in the HOPE Trust Health Care Plan and do not wish to add any additional dependents at this time *or* change my plan selection for the next plan year. This enrollment shall remain in effect until my employer is notified by me to the contrary or until coverage is terminated in accordance with plan provisions.

Employee Name (Print): _____

Employee Signature: _____ **Date Signed:** _____

ACCEPT (OR CHANGE PLAN)

I accept the opportunity to enroll myself and my selected dependents (if applicable) *or* to add additional dependents *or* to change my plan selection for the next plan year in the HOPE Trust Health Care Plan and at the prevailing cost (if any) required for participation. This enrollment shall remain in effect until my employer is notified by me to the contrary or until coverage is terminated in accordance with plan provisions.
*** (Additional **Employee Enrollment Form** must be completed.) ***

Employee Name (Print): _____

Employee Signature: _____ **Date Signed:** _____

DECLINE

I DO NOT WISH TO ENROLL myself or my selected dependents in the HOPE Trust Health Care Plan at this time and understand the option to enroll at any future time will be limited to special enrollment opportunities or during open enrollments as provided under the terms of the HOPE Trust Health Care Plan.

Employee Name (Print): _____

Employee Signature: _____ **Date Signed:** _____

EMPLOYER USE ONLY -- ENROLLMENT OFFERED FOR:

☐ New Hire/New Full-Time (FT Hire Date: _____)
☐ Special Enrollment (Event: _____)
☐ Open Enrollment (MM/YYYY): _____/_____

HOPE TRUST
Health Options for Public Entities

Employee Enrollment Form

EMPLOYER MUST FAX COMPLETED FORM to SRM (HOPE Trust Plan Administrator) at 309-543-6607

REASON FOR ENROLLMENT

(to be completed by Employer; check all boxes that apply)

New Enrollment: ☐ New Hire/Full-Time (Date: _____) ☐ Open Enrollment

Special Enrollment:
☐ Dependent Spouse Addition ☐ Dependent Child Addition
☐ Involuntary Loss of Coverage ☐ Birth ☐ Adoption
☐ Marriage ☐ Other: _____

Date of Event Triggering Special Enrollment (mm/dd/yy): _____

EMPLOYEE INFORMATION

Date of Hire (Full-Time) (mm/dd/yy) | Social Security Number

Last Name | First Name | Middle Initial | Date of Birth (mm/dd/yy)

Home Address | City | State | ZIP | Male / Female (Gender, circle one)

Home (or Cell) Phone Number | Single / Widowed or Divorced / Married or Civil Union (Marital Status, circle one)

E-mail Address

DEPENDENTS TO BE COVERED

First Name	M.I.	Last Name (If Different)	Soc. Sec. #	Relationship (Spouse/Son/Daughter)	Date of Birth (mm/dd/yy)

PLAN OPTION SELECTION

Traditional Major Medical Plan → [ ] Self [ ] Spouse [ ] Child(ren)

QHDHP (HSA-Compatible) → [ ] Self [ ] Spouse [ ] Child(ren)

Health Reimbursement Plan (HRP) → [ ] Self [ ] Spouse [ ] Child(ren)

Dental & Vision Plan *(Optional)*
[ ] Self [ ] Spouse [ ] Child(ren)

[ ] Other; *if Other, please explain:*

NOTE: A covered employee and his/her covered dependents must generally be covered under the same plan option, with the exception of dependent election or declination of Dental & Vision coverage.

Continued on next page -->

Employee Enrollment Form (continued)

EMPLOYER MUST FAX COMPLETED FORM to SRM (HOPE Trust Plan Administrator) at 309-543-6607

INFORMATION ABOUT OTHER COVERAGE

Will you or any of your covered dependents (spouse and/or child(ren)) keep other coverage in addition to this coverage? ☐ ☐

Are you or any of your covered dependents (spouse and/or child(ren)) covered through a **spouse's employer plan**? ☐ ☐

Spouse's Employer	Insurance Company	Who is Covered on Spouse's Plan? (circle all that apply) Self	Spouse	Child(ren)

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Medicare**? ☐ ☐

If Yes, Who? ___ Self ___ Spouse ___ Child(ren) If Yes, Why? ___ Age ___ Disability ___ Kidney Failure

Type of Coverage: ___ Part A ___ Part B ___ Part D

Are any of your covered dependents (spouse and/or child(ren)) totally or temporarily disabled? ☐ ☐

If Yes, Who? _____ Date of Disability: _____

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Medicaid**? ☐ ☐

If Yes, Who? ☐ Self ☐ Spouse ☐ Child(ren)

Are you or any of your covered dependents (spouse and/or child(ren)) covered through **Tri-Care**? ☐ ☐

If Yes, Who? ☐ Self ☐ Spouse ☐ Child(ren)

MEDICAL HISTORY

Have you or any of your covered dependents (spouse and/or child(ren)) been diagnosed with or have planned future surgeries or treatments for heart disease, cancer, neck or back disorder, kidney/renal disease or failure, organ or tissue transplant, or AIDS/HIV/autoimmune disease?

YES **NO** If Yes, indicate Who, and please provide an additional explanation below *(attach additional pages, if needed)* :

ACKNOWLEDGEMENT & SIGNATURE

I understand, agree, and represent that I have read this document or it has been read to me; the answers provided within this entire Employee Enrolllment Form are, to the best of my knowledge and belief, true and complete; and if I intentionally omit or provide false information on or in relation to this Employee Enrollment Form, then this coverage may be cancelled retroactively, in which case any claim I incur may not be paid by the plan and I may face legal liability. I understand further that the information I have provided in this Employee Enrollment Form will be used by the plan and its affiliates to make decisions about eligibility, enrollment, and underwriting. Finally, I authorize any physician, nurse, hospital, dentist, other person, or firm to obtain from the plan information and copies or records pertaining to medical and prescription expenses incurred by me or my family members enrolled in the plan. A photographic copy of this Employee Enrollment Form and Acknowledgement & Signature shall be as valic as the original.

_____ Signature of Employee

_____ Date

HOPE TRUST
Health Options for Public Entities

Membership Addition/Termination/Change Transmittal Form

EMPLOYER MUST FAX COMPLETED FORM to SRM (HOPE Trust Plan Administrator) at 309-543-6607

Employer Name: _____

ADD NEW MEMBERS

*(Employee must also complete separate **EMPLOYEE FORM** ; include when sending in this form.)*

Name	*Plan Choice (Major Medical, HRP, etc.)*	*Effective Date of Coverage*

TERMINATE EXISTING MEMBERS

Name	*Coverage Continuation Packet Send* COBRA	IMRF	*Effective Date of Termination*
	YES / NO	YES / NO	
	YES / NO	YES / NO	

CHANGE COVERAGE OR ENROLLMENT INFO FOR EXISTING MEMBERS

(e.g., add newborn, add new spouse, change from Major Medical to HRP, change address, change last name, etc.)
*(Employee may also need to complete separate **EMPLOYEE FORM** ; if so, include when sending in this form.)*

Present Name Under Plan	*Requested Change*	*Effective Date of Change*

_____ _____
Signature of Employer Representative Date

Health Savings Account Agreement Form

Print clearly and return this completed Agreement to Human Resources/Benefits Dept.
Only complete this form is accepting the HOPE 4000 plan. Be sure to follow the instructions on the next few pages to set up your HSA account.

Employer Name			
Name (Last, First, MI)		**Social Security Number or ID Number**	
Street Address	**City**	**State**	**ZIP Code**
Effective Date of Election	**Type of Election**		**Date of Birth-MM/DD/YY**
	☐ New Election ☐ New Hire Election ☐ Change in Election ☐ Stop Election		

Health Savings Account Election **HSA Custodian – HSA Central**	
Per Pay Period Salary Reduction Amount **Check the medical plan coverage tier that you have enrolled in.** ☐ **Employee Only HDHP Coverage** ☐ **Family HDHP Coverage**	**Indicate the Per Pay Period Amount that you wish to contribute to the HSA** $ _____

I understand:

- I have elected to have pretax deductions from my pay based on the number of pay periods as set up by my employer during the plan year and that this election will continue until this Agreement is amended or terminated as allowed under the Plan.
- The HSA is an individually owned and managed account and that I am responsible to understand the HSA.
- My employer cannot provide tax advice or confirm that I meet the eligibility requirements for the HSA.
- I may obtain information about HSAs from a qualified tax professional or IRS Publication 969.
- Pretax deductions reduce my compensation for tax purposes which reduces my Social Security benefits.
- I am responsible to understand the eligibility requirements for contributions made to my HSA and by my signature below, state that I do qualify to make contributions to this account.
- I must assume responsibility for this individually managed account for:
  - Determining my eligibility for the HSA each year a contribution is made
  - Ensuring that all contributions made to my account are within the limits set forth by the tax laws
  - Any tax consequences related to contributions (including rollover contributions) and distributions
  - Keeping all documentation including insurance plan explanation of benefits forms and itemized receipts to support distributions taken from my account
  - Paying any associated banking fees that may be billed to me
- If married and electing family HDHP coverage, I certify that my spouse does not have any non-HDHP coverage.
- Federal law requires financial institutions to obtain, verify and record information that identifies each person with an account.
- My employer may change my election if necessary in order to satisfy certain provisions of the Internal Revenue Code.
- My election and this Agreement will cease upon termination of employment.
- Expenses for which I claim a tax deduction under my income tax return cannot also be paid from my HSA.
- The Health Savings Account, and my rights and obligations under this HSA, as specified in the HSA materials.
- This Agreement cancels any prior election agreement I have made and cannot be changed except as stated in my employer's Plan.

I agree to notify my employer immediately if I experience any changes that would impact my eligibility to participate in an HSA.

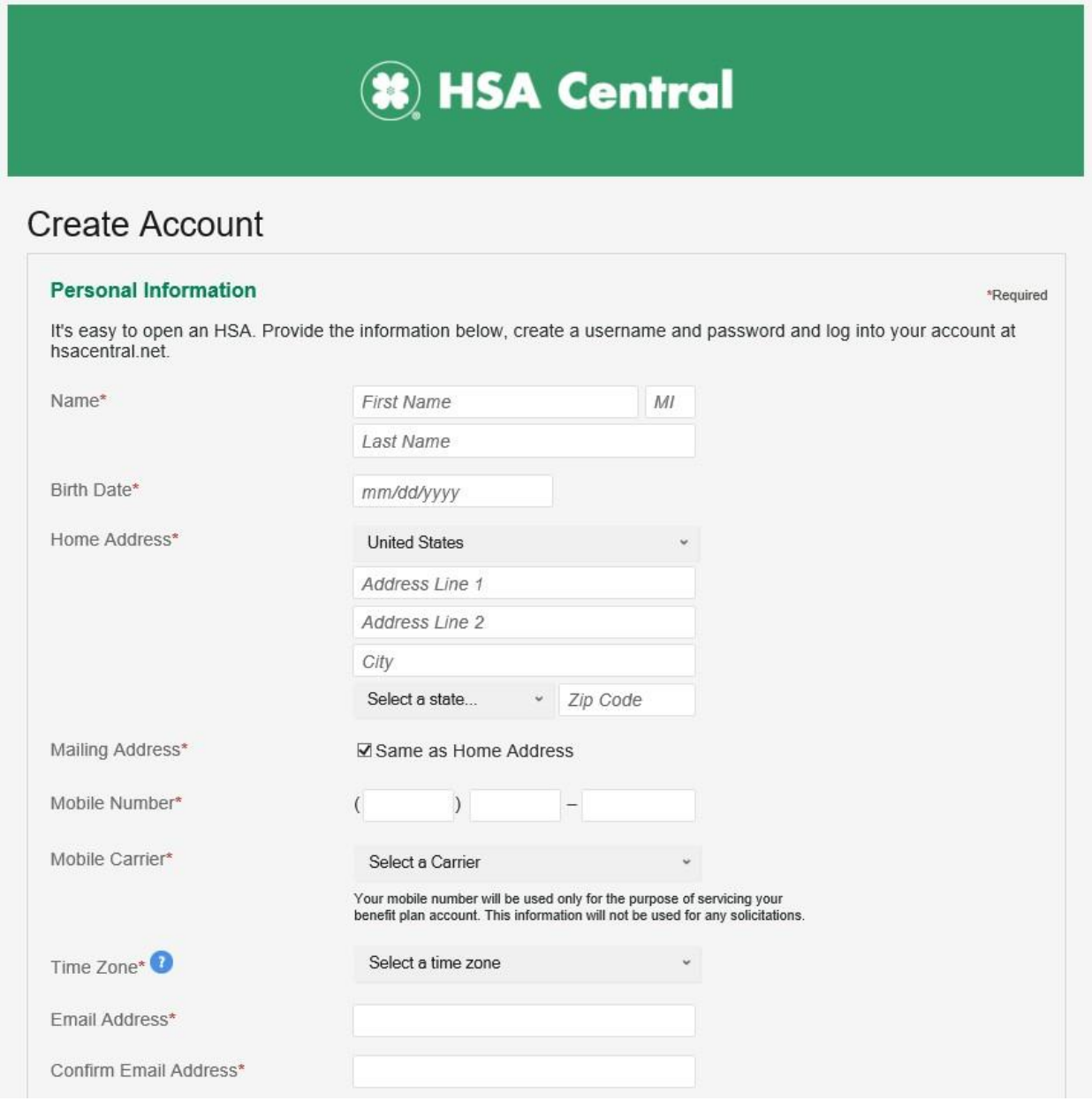
Employee Signature _____ **Date** _____

HSA Central- Online Account Opening

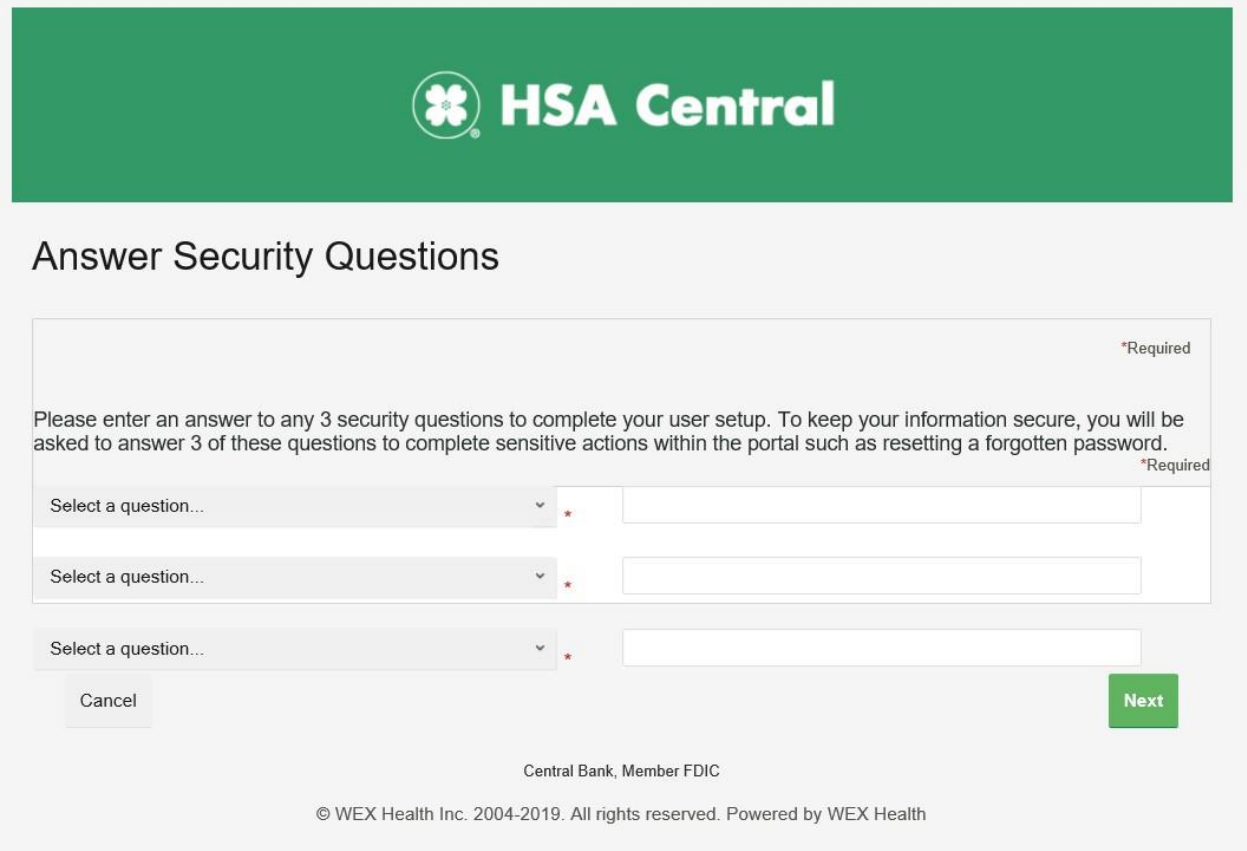
Employer Name: **JACKSON COUNTY, IL**

HSA Central Employer Online Account Opening URL:
https://centralparticipant.lh1ondemand.com/Login.aspx?sec=ASF-CB1092

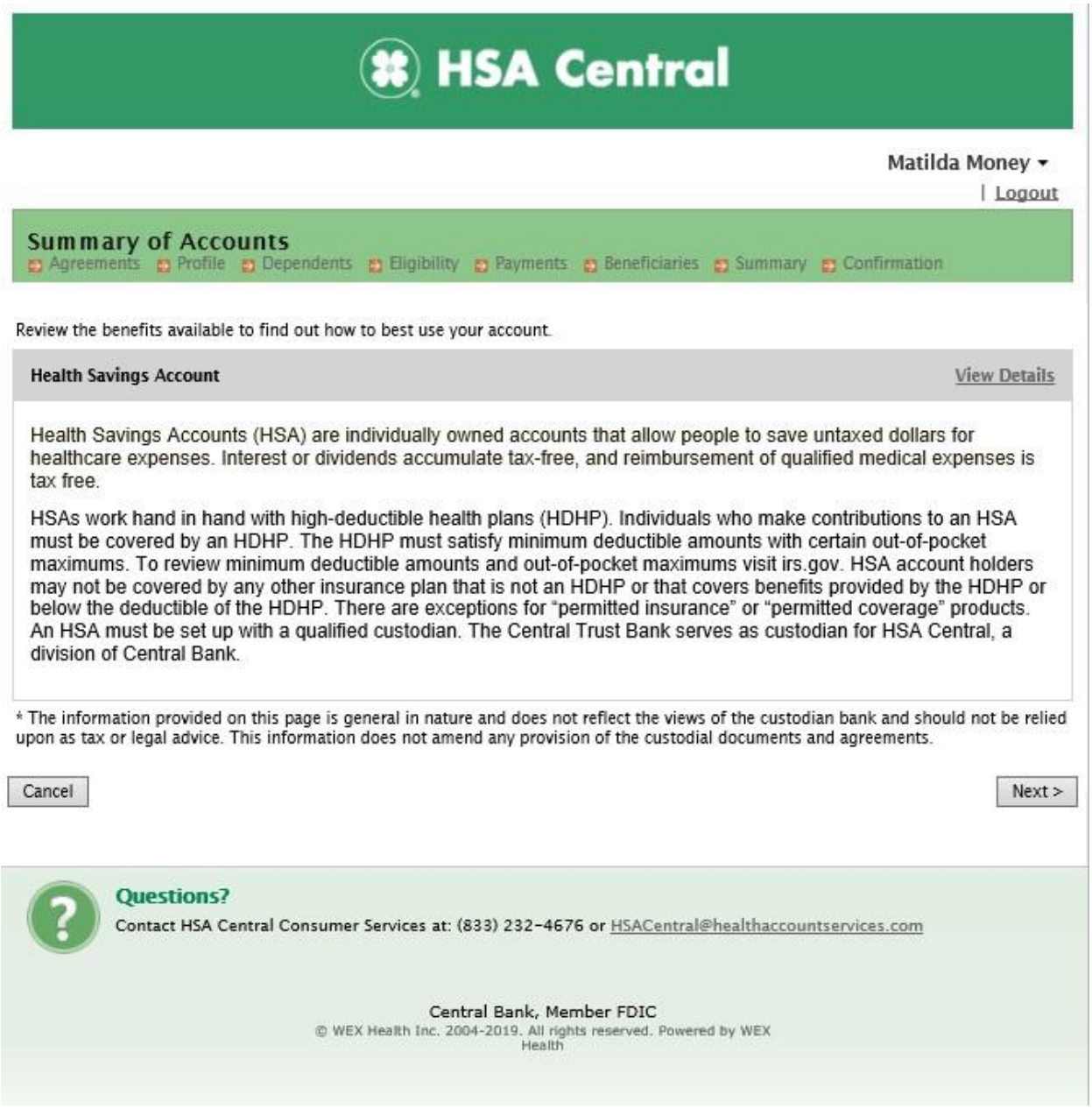
1. Provide your Personal Information and create your username and password to open your Health Savings Account (HSA). Your username and password will be used when logging into your HSA at HSACentral.net



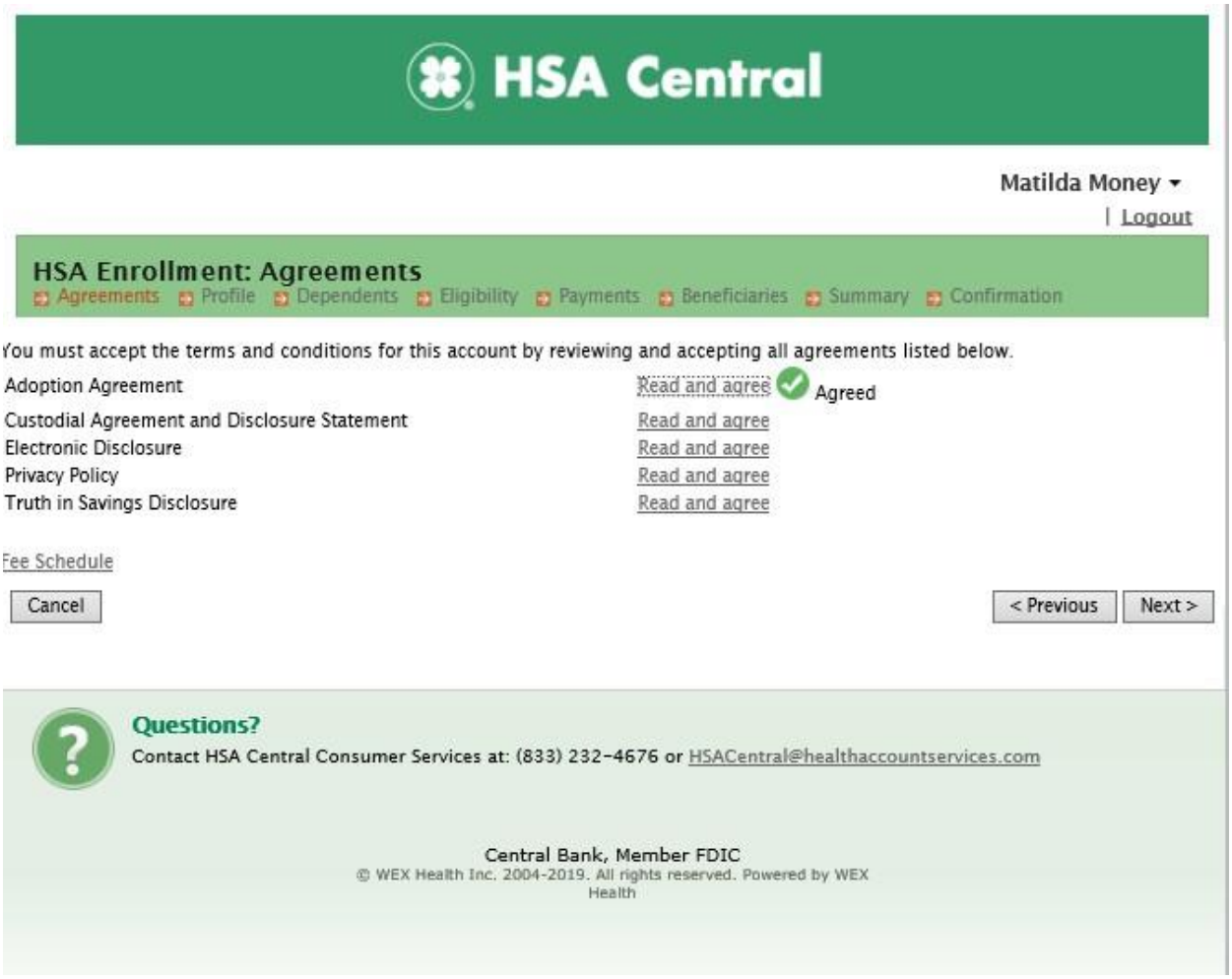
2. Establish Security questions for your HSA.



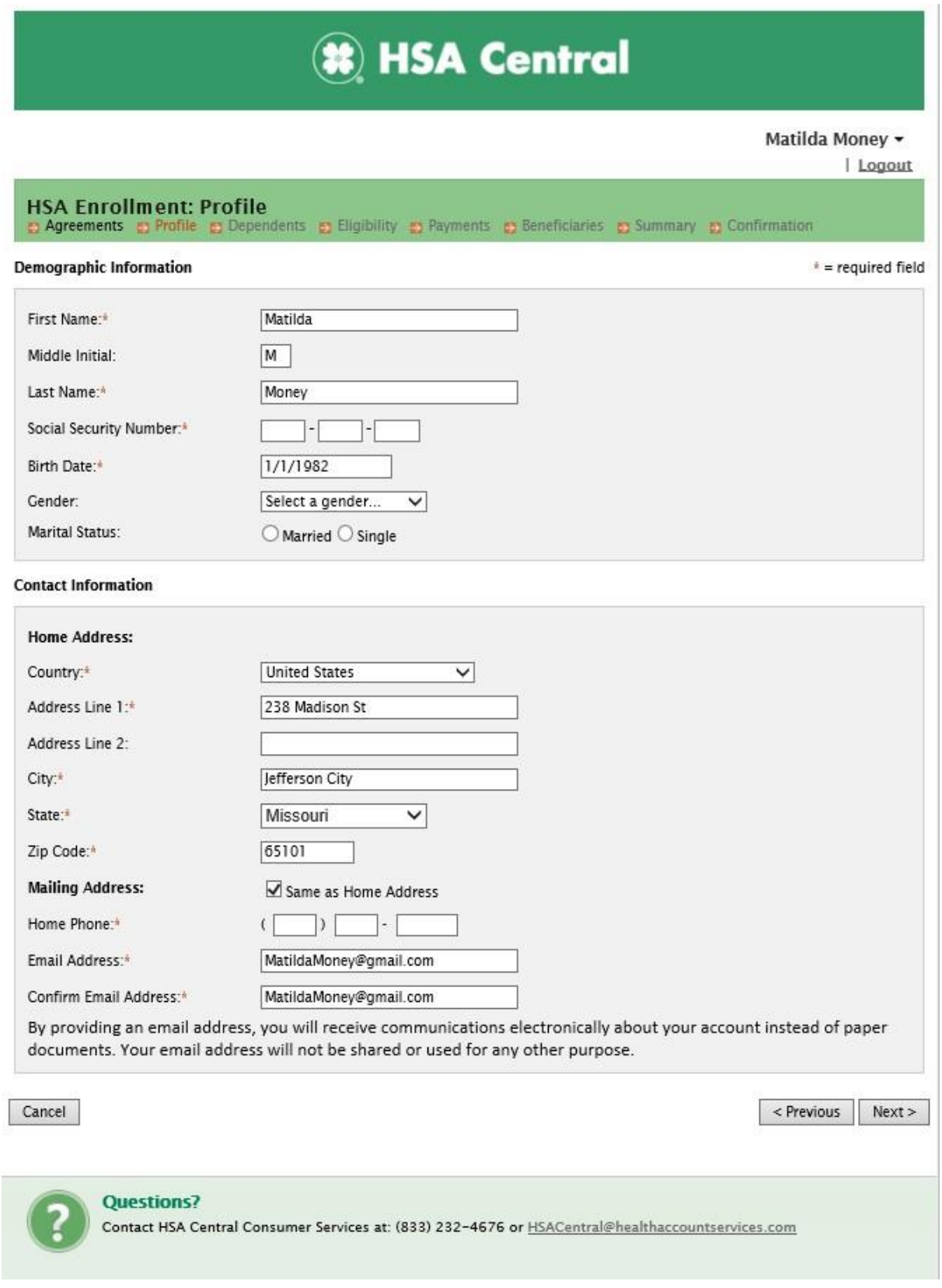
3. Review the information.



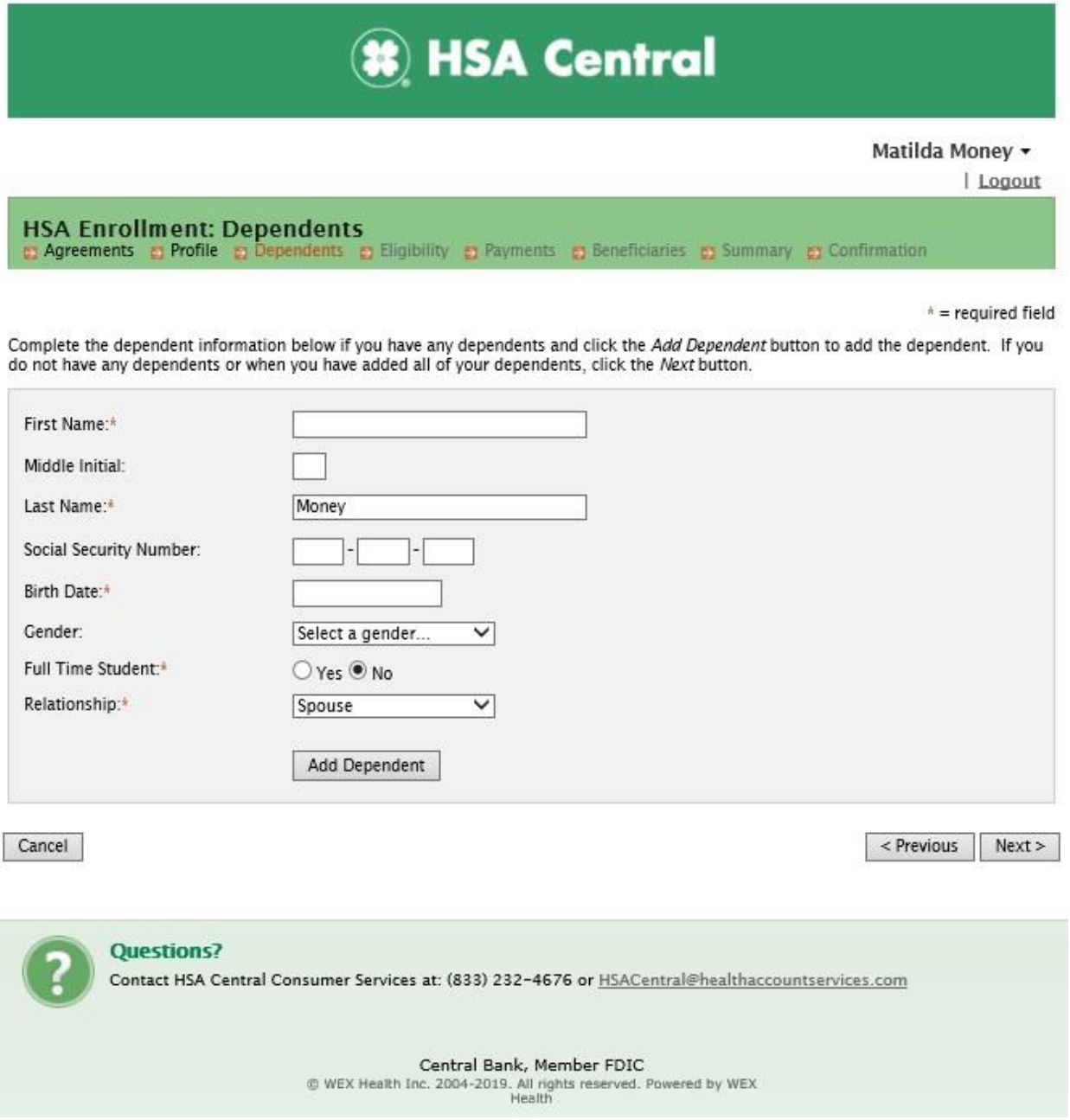
4. Click the *Read and agree* link to accept the Agreements and Disclosures for your HSA.



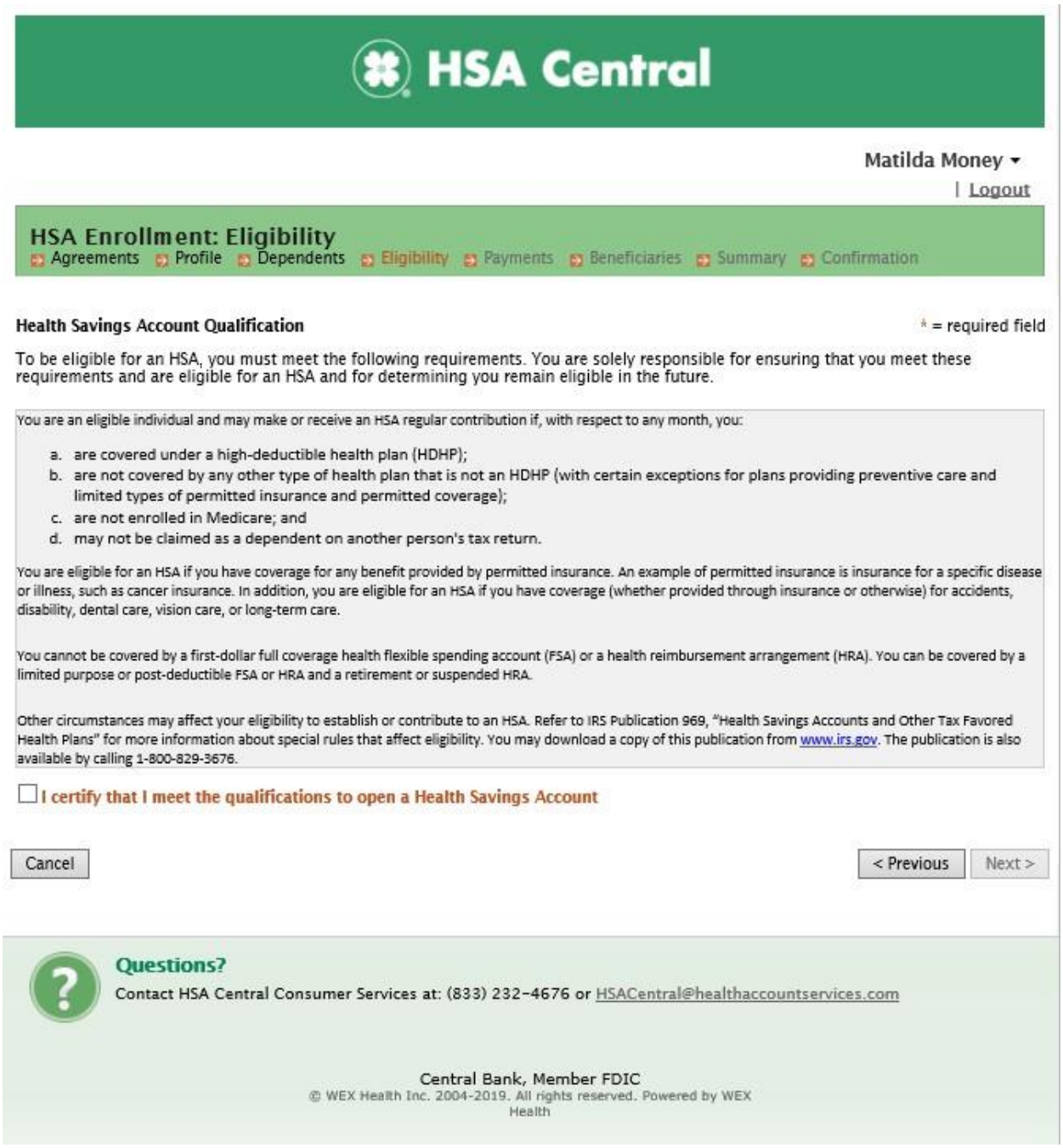
5. Complete your Demographic information including SSN and phone number.



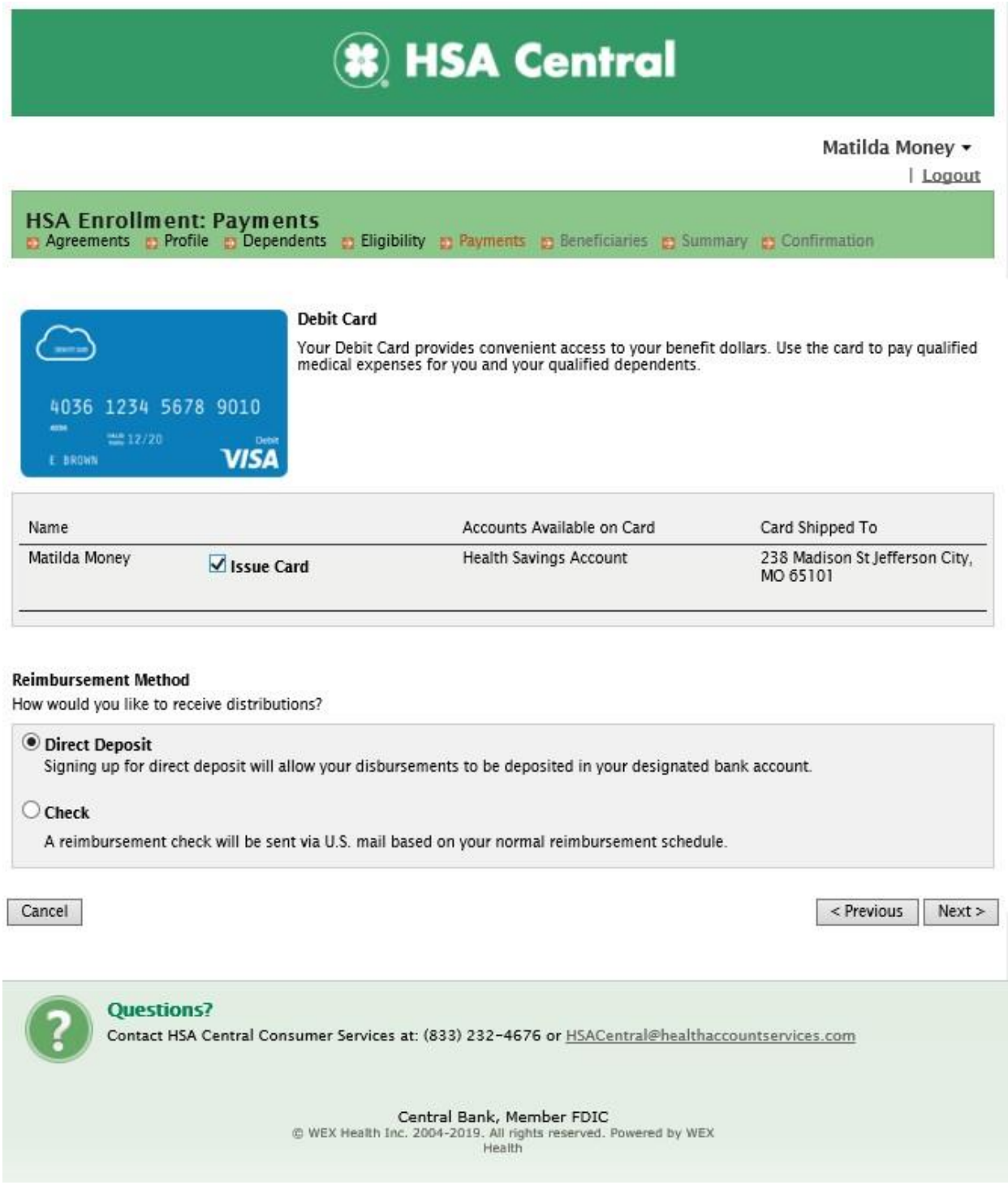
6. Add any dependents or a spouse to your HSA profile. This makes it easy to associate healthcare expenses with specific individuals within your household, assign them as beneficiaries later, or issue them an HSA Central Debit Mastercard used for eligible healthcare expenses related to your HSA.



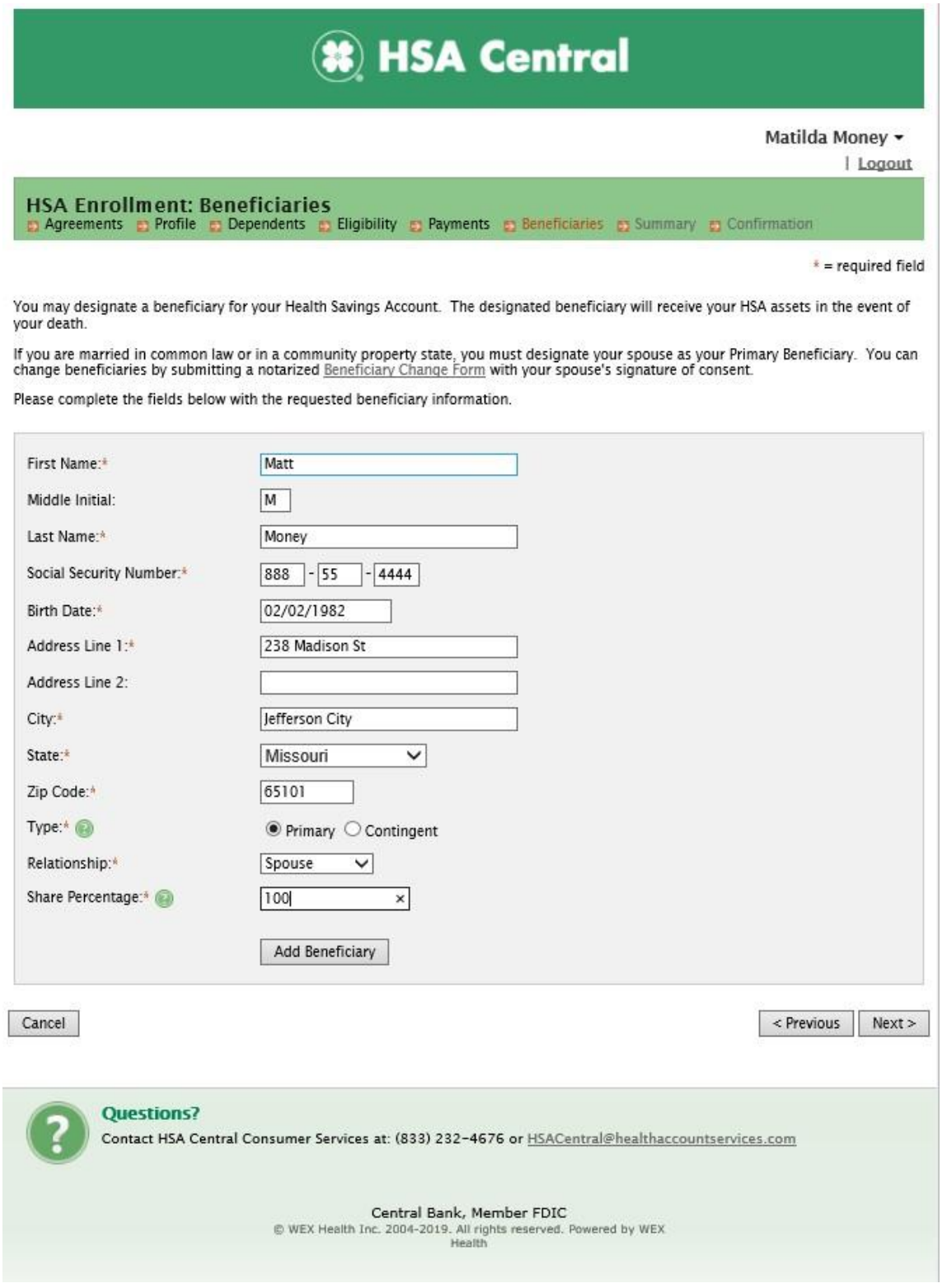
7. Ensure you meet the eligibility requirements and have a high-deductible health plan to open the HSA. Check the box to certify you're eligible. Select your health plan's level of coverage from the drop down.



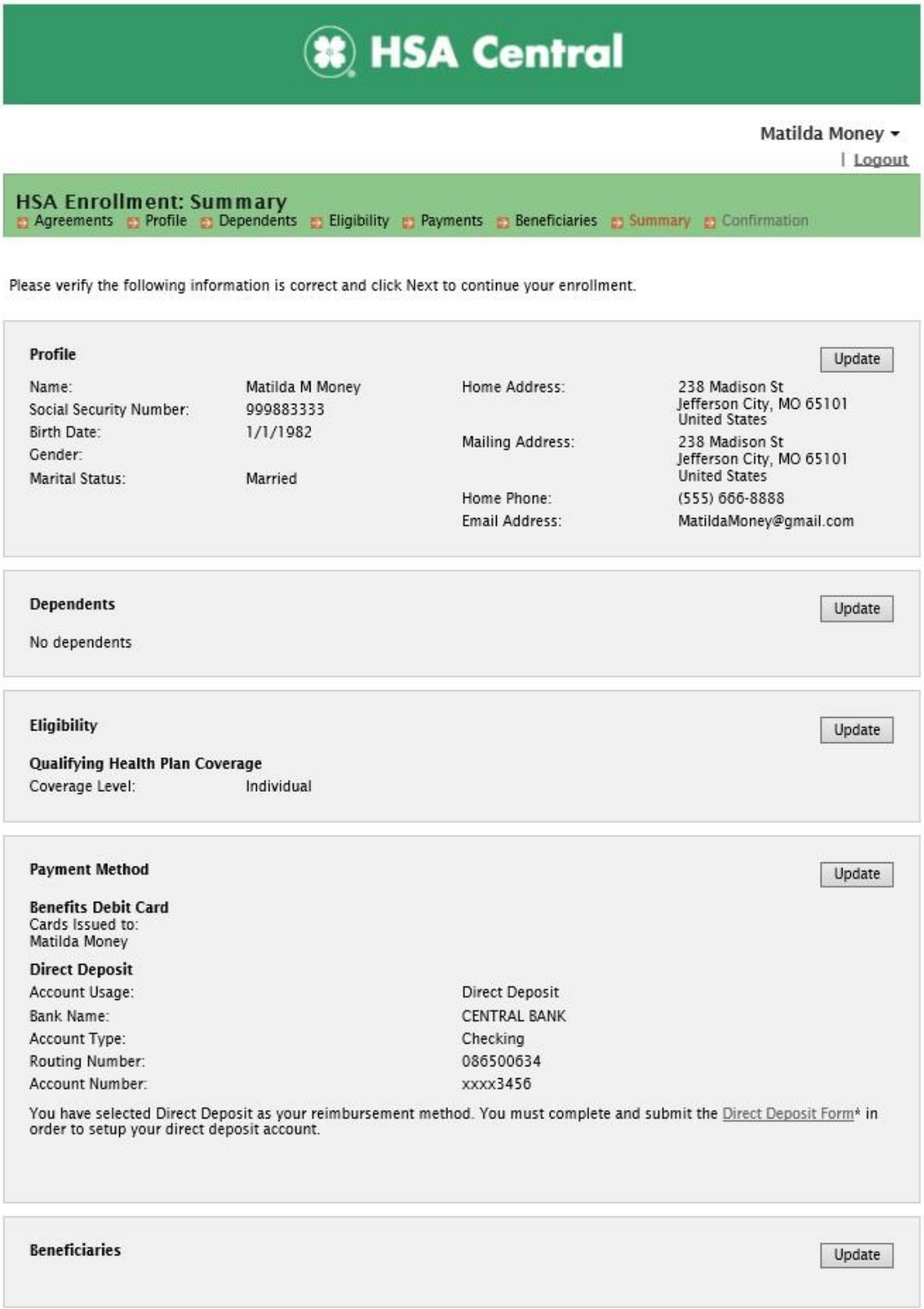
8. Select the *Issue Card* box to have your HSA Central Debit Mastercard mailed to you. You can also add a bank account that will make it easier later to reimburse yourself for eligible medical expenses where you might not have used your HSA Central debit card or to add additional contributions to your HSA.



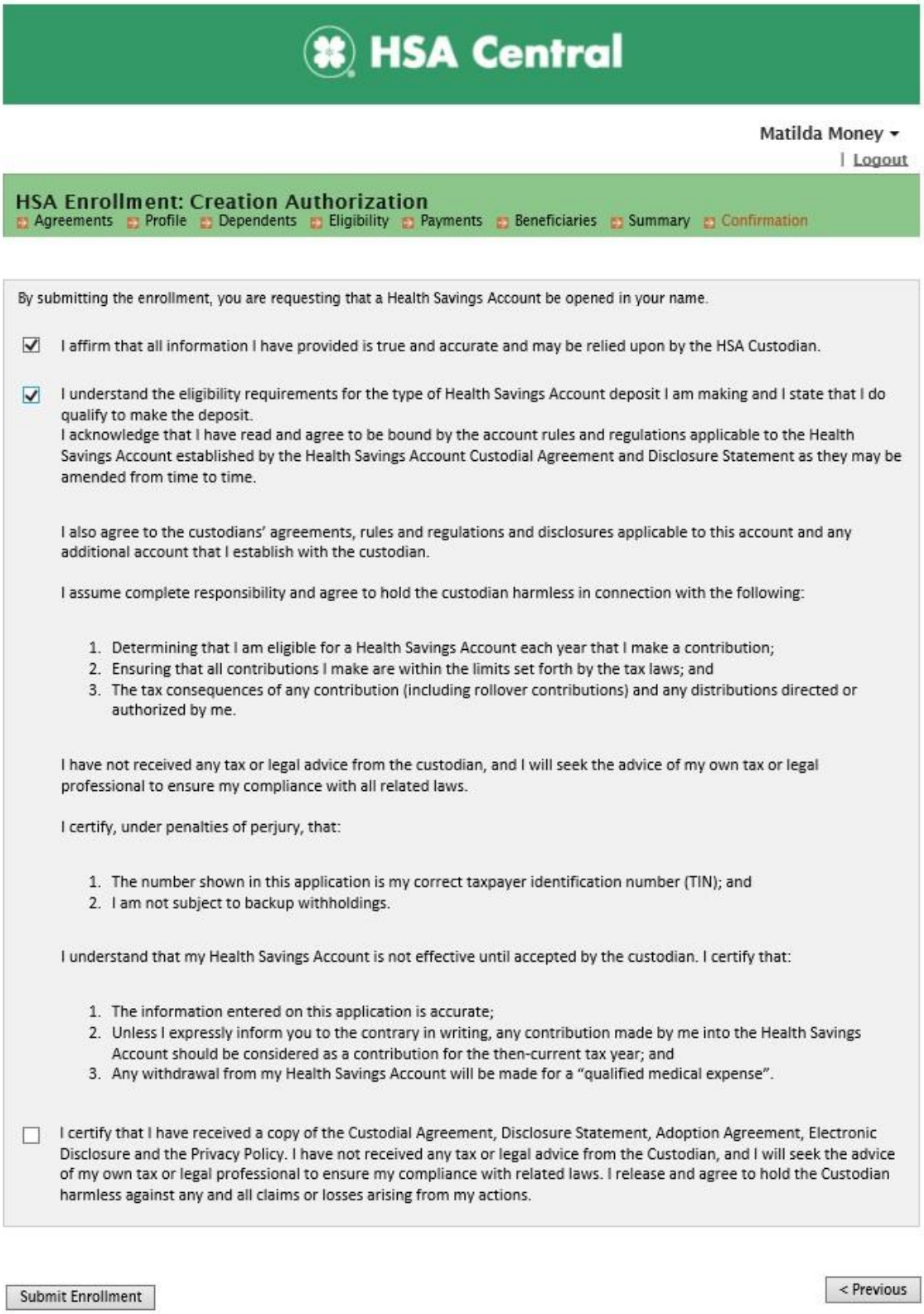
9. Add your Beneficiaries by completing the fields, or you can select dependents you previously added.



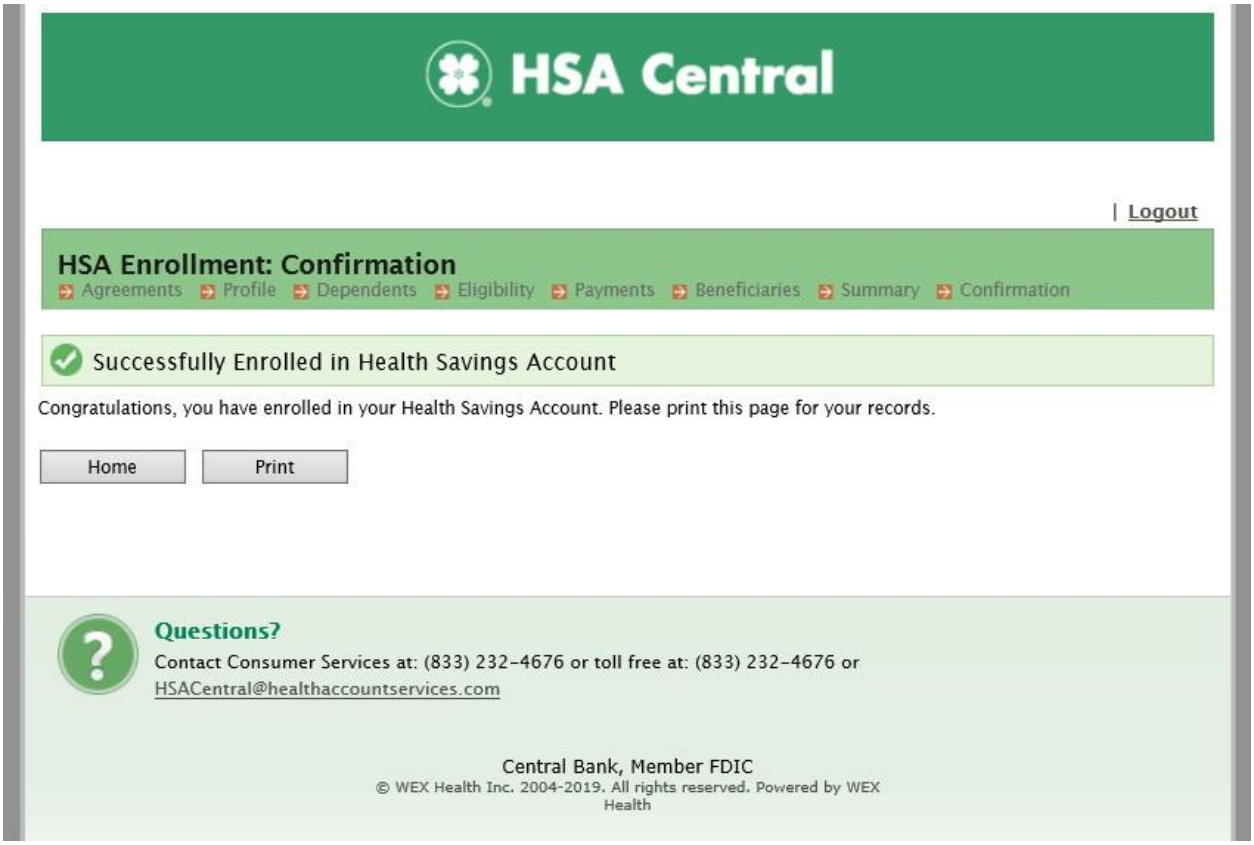
10. Verify the information you entered is correct.



11. Check the boxes for final authorization and Submit.



12. Your HSA enrollment is complete.



Flexible Spending Account Agreement Form

Print clearly and return this completed Agreement to Human Resources/Benefits Dept.

Only complete this form if accepting the HOPE 1000 plan.

Employer Name			
Name (Last, First, MI)		**Social Security Number or ID Number**	
Street Address	**City**	**State**	**ZIP Code**
Effective Date of Election	**Type of Election**		**Date of Birth-MM/PP/YY**
	☐ Open Enrollment Election ☐ New Hire Election		

General-Purpose Health Care Flexible Spending Account (FSA) Election – Medical, dental, vision, hearing care expenses

Qualified expenses include medical, dental, vision, and hearing expenses **for you & your tax dependents** that are not reimbursed under any other source.

Plan Year Salary Reduction Amount *Check your plan for the maximum limit.*	Per Pay Period $_____	Plan Year Election $_____

Limited-Purpose Health Care Flexible Spending Account (FSA) Election – Dental and vision care expenses

HSA-compatible FSA and includes qualified expenses include dental and vision expenses **for you & your tax dependents** that are not reimbursed under any other source.

Plan Year Salary Reduction Amount *Check your plan for the maximum limit.*	Per Pay Period $ _____	Plan Year Election $_____

Dependent Care Flexible Spending Account (DCFSA) Election - Child/elder daycare expenses

Qualified expenses are those incurred primarily for the protection and well-being of a child or elder dependent while you work. **DO NOT include medical expenses for your dependents in the DCFSA election. Include these expenses in your election for the Health Care FSA program below.**

Plan Year Salary Reduction Amount *Maximum $5,000, or $2,500 if married and filing separate income tax returns.*	Per Pay Period $_____	Plan Year Election $_____

Claim reimbursement is sent directly to a bank account of your choice, and you will be notified by email/text alert each time reimbursement is issued. Note: If you have previously signed up for this option and do not wish to change the information ASIFlex has on file from a previous year, there is no need to complete the following section.

☐ Please use account information below to set up direct deposit to my bank account and send email/text alerts of my account activity. Attach a voided check or copy of a check to this form. Note: Standard text message charges may apply from your wireless provider.

Name of Financial Institution/Bank _____ Bank Routing Number (9-digit) _____

Account number _____ Type of Account: ☐ Checking ☐ Savings

Email: _____ Cell Phone: _____ Mobile Carrier: _____

☐ Mail a check to my home address. ASIFlex and your employer are not responsible for lost or delayed mail.

I understand:

- I have elected to have pretax deductions from my pay based on the number of pay periods as set up by my employer during the plan year, and that this election will continue until this Agreement is amended or terminated as allowed under the Plan.
- Pretax deductions reduce my compensation for tax purposes which reduces my Social Security benefits.
- I cannot change or terminate my election unless I experience a qualified change in status as allowed under the Plan.
- My employer may change my election if necessary in order to satisfy certain provisions of the Internal Revenue Code.
- My election and this Agreement will cease upon termination of employment.
- Complete claims with correct supporting documentation must be submitted timely as described in the Plan in order to be considered for reimbursement.
- Expenses for which I claim a tax deduction under my income tax return cannot also be reimbursed under this Plan.
- Unused funds are forfeited at the end of the Plan Year or as otherwise defined in the Plan.
- The Dependent Care FSA and Health Care FSA benefits, and my rights and obligations under this plan, as specified in my employer's Plan materials.
- This Agreement cancels any prior election agreement I have made under the Plan and cannot be changed except as stated in my employer's Plan.

Employee Signature _____ **Date** _____