School Staff Employee Packet Checklist

1. Application for Employment (Entered in Paylocity by Applicant)
2. Transcripts (Copies for the employee file)
3. Teaching License (copy for the employee file)
4. Authorization to Conduct Background Check (CHIRP)
5. Criminal Background Check, including fingerprint background checks, for school employees.
6. Online Offender Database Check

   National Sex Offender Public Website

   Violent Offender Registry

   School keeps a paper or digital copy of the results on file and enters the date the results were received into the Virtus System)

7. Faith's Law Form #1 – Authorization for Release of Sexual Misconduct Related Information for Current/Former Employers (**This needs to be filled out for all former employers with whom the candidate has had contact with minors.)**
8. Faith's Law Form #2 – Sexual Misconduct Disclosure Template for Applicant (This is to be filled out by the applicant and given to the School)
9. Employment Authorization Form Approved by Chancery (School to complete, email or fax to Chancery)
10. Protecting God's Children Training Certificate of Completion
11. Sexual Harassment Prevention Training (Link in Virtus System)
12. Mandated Reporter Training Certificate of Completion (Link in Virtus System)
13. Guidelines for working with youth (Link in Virtus System)
14. Sexual Misconduct Norms (Link in Virtus System)
15. Code of Pastoral Conduct (Link in Virtus System)
16. Code for the Pastoral use of Technology and social media guidelines (Link in Virtus System)
17. IDPH Report of Tuberculosis Screening
18. Statement of Good Health
19. I-9 Proof of Identity (Make copies of proof of identification and attach to I-9 and maintain in the employee's file)
20. W-4 Federal and W-4 state (School to maintain in employee's file)
21. Direct Deposit Form
22. Summary of Benefits (Given to the employee)
23. Health Insurance Enrollment Card (for Full-Time Employees) must be returned to the Health Insurance Department)
24. Marketplace Coverage Options (to be given to employees)
25. Section 125 form (for employees who choose dependent coverage **ONLY**)
26. Diocesan Pension Plan (contact Matt Young for information in the plan)
27. 403(b) Retirement Plan Information
28. Emergency Notification form (School retains this)
29. Employee Handbook and Receipt (retain receipt in employee file. Password is dmalloy!) Employee Handbook
30. Diocese Payroll Addition, Change, or Termination Form (School to complete and return to Payroll office – cdrpayroll@rockforddiocese.org)

Authorization to Conduct Background Check
Catholic Diocese of Rockford

(**CHIRP**) **C**riminal **H**istory **I**nformation **R**esponse **P**rocess

AUTHORIZATION TO CONDUCT CRIMINAL BACKGROUND INVESTIGATION AND TO DISCLOSE CRIMINAL BACKGROUND INFORMATION

I hereby give my consent to the Illinois State Police to conduct a criminal background check on me from all states in which I have resided or worked and authorize the Illinois State Police representatives to disclose to _____(name of Diocesan entity) the information obtained through such investigations.

I understand that date of birth, sex and race are being requested only for the purpose of identification in obtaining accurate retrieval of records and will not be used for discriminatory purposes.

Please Print

Last Name:_____ Middle Initial:_____

First Name:_____

Other Names Used by Me:_____

Date of Birth:_____ (ex: MM/DD/YYYY)

Address:_____
Street City State Zip

Gender: ❑ Male ❑ Female

Race:_____
(American Indian or Alaskan Native, Asian or Pacific Islander, Black, White or Unknown)

Applicant Signature:_____

Date:_____

For Office Use Only

Background check results were received on:_____
(Date)

State Sex Offender Registry:_____ ❑ Clear https://www.isp.state.il.us/sor/
(Date)

National Sex Offender Registry:_____ ❑ Clear https://www.nsopw.gov/
(Date)

Sex Offender Registries checked by:_____

AUTHORIZATION FOR RELEASE OF SEXUAL MISCONDUCT-RELATED INFORMATION AND CURRENT/FORMER EMPLOYER RESPONSE TEMPLATE

This standardized form is based on a template developed by the Illinois State Board of Education (ISBE) pursuant to 105 ILCS 5/22-94 of the Illinois School Code. This completed form and any information or records received by the hiring entity shall not be considered public records.

Instructions for Applicant:

Complete one form for each current employer (if any). Additionally, complete one form for each former employer that falls within any of the categories below:

1. A public or nonpublic elementary or secondary school.
2. An employer that, at the time of your employment, contracted with a public or nonpublic elementary or secondary school to provide services, including, but not limited to, employers that provided food services, bus services, or other transportation services. This category applies only if, as part of your employment with the employer, you had engaged in -- or there was the possibility that you would engage in -- the care, supervision, guidance, control of, or routine interaction with children or students.
3. Any other employer for which you, as part of your employment with the employer, did engage in or had the possibility of engaging in the care, supervision, guidance, control of or routine interaction with children or students.

Please be advised that if you are licensed by ISBE, the hiring entity is required to verify the employment history you report by checking ISBE's educator licensure database. The responses the hiring entity receives from your current and former employers will be used to evaluate your fitness to be hired or for continued employment. An applicant who provides false information or willfully fails to disclose information shall be subject to denial of employment, or if already hired, shall be subject to discipline, up to and including termination.

Section 1: Hiring Entity Information *(to be completed by Hiring Entity)*

Hiring Entity's Name:	Contact Person:
Address:	City, State, ZIP
Telephone Number:	Email:
Sent to Current/Former Employer By (insert name): On (insert date):	Received at Hiring Entity: By (insert name): On (insert date):

Section 2: Applicant Information *(to be completed by Applicant)*

Name: (First, Middle, Last):	Any former names by which the Applicant has been identified:
Date of Birth:	Last Four Digits of Social Security Number:
IEIN (if applicable):	Email:
Street Address:	City, State, ZIP:

Section 3: Current/Former Employer Information *(to be completed by Applicant)*

Employer:	Contact Person:
Address:	City, State, ZIP
Telephone Number:	Email:
Position Held:	Approximate Dates of Employment:

Section 4: Authorization for Disclosure of Employment Information and Release of Employer Liability *(to be completed by Applicant)*

By signing this form, I do hereby authorize my current/former employer identified in Section 3, above, to disclose to the hiring entity identified in Section 1, above, the following information and any records related to that information:

1. The dates of my current/former employment;
2. A statement as to whether I have ever been the subject of an allegation of "sexual misconduct," as defined in 105 ILCS 5/22-85.5 (Sexual Misconduct), (unless a subsequent investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated);
3. A statement as to whether I have ever been discharged from, been asked to resign from, resigned from, or otherwise been separated from any employment; been disciplined by the employer; or had an employment contract not renewed due to an adjudication or finding of Sexual Misconduct, or while an allegation of Sexual Misconduct against me was pending or under investigation (unless a subsequent investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated);
4. A statement as to whether I have ever had a license or certificate suspended, surrendered, or revoked; or had an application for licensure, approval, or endorsement denied due to an adjudication or finding of Sexual Misconduct or while an allegation of Sexual Misconduct against me was pending or under investigation (unless a subsequent investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated); and
5. Any other pertinent records, documentation, or information related to items 2 through 4 above.

Further, by signing this form, I do hereby release my current/former employer identified in Section 3, above, from any criminal or civil liability that may arise from the disclosure of information and records authorized under this Section 4 to the extent such release is permitted by law.

Applicant Signature Printed Name Date

Section 5: Information Request *(to be completed by Applicant's current or former employer)*
This form must be completed and returned to the hiring entity listed in Section 1 within 20 days of receipt.

Position held by Applicant:	Dates of Employment:
Person Completing Form:	Title:
Telephone Number:	Email:

For purposes of the following requests, the term "sexual misconduct," as defined in 105 ILCS 5/22-85.5 (Sexual Misconduct), means any act, including, but not limited to, any verbal, nonverbal, written, or electronic communication or physical activity, that:

1. Applicant committed as an employee or agent of a school district, charter school, or nonpublic school during which time Applicant engaged in or had the possibility of engaging in the care, supervision, guidance, control of or routine interaction with students; and
2. Was directed toward or with a student to establish a romantic or sexual relationship with the student. Such an act includes, but is not limited to, any of the following:
    a. A sexual or romantic invitation;
    b. Dating or soliciting a date;
    c. Engaging in sexualized or romantic dialog;
    d. Making sexually suggestive comments that were directed toward or with a student;
    e. Self-disclosure or physical exposure of a sexual, romantic, or erotic nature; and
    f. A sexual, indecent, romantic, or erotic contact with the student.

1.	To the best of your knowledge, has Applicant ever been the subject of an allegation of Sexual Misconduct? Check no if a subsequent investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated.	[ ] Yes* [ ] No or [ ] I have no records or other evidence pertaining to this question. I have no knowledge of information pertaining to the Applicant that would disqualify Applicant from employment.
2.	To the best of your knowledge, has Applicant ever been discharged from, been asked to resign from, resigned from, or otherwise been separated from any employment; been disciplined by you (the employer); or had an employment contract not renewed due to an adjudication or finding of Sexual Misconduct, or while an allegation of Sexual Misconduct against Applicant was pending or under investigation? Check no if a subsequent investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated.	[ ] Yes* [ ] No or [ ] I have no records or other evidence pertaining to this question. I have no knowledge of information pertaining to the Applicant that would disqualify Applicant from employment.
3.	To the best of your knowledge, has Applicant ever had a license or certificate suspended, surrendered, or revoked; or had an application for licensure, approval, or endorsement denied due to an adjudication or finding of Sexual Misconduct or while an allegation of Sexual Misconduct against Applicant was pending or under investigation? Check no if a subsequent investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated.	[ ] Yes* [ ] No or [ ] I have no records or other evidence pertaining to this question. I have no knowledge of information pertaining to the Applicant that would disqualify Applicant from employment.

*If your answer to any of the above questions is "yes", you must provide any records and information in your control or possession related to the affirmative response. Please provide the information in the space below and attach any responsive records to this form. Additional pages of information may be attached.

I have read and understand the contents of this form. I certify that, to the best of my knowledge, the responses provided above are accurate, and the records provided in connection with these responses are true and correct.

Current/Former Employer Signature Printed Name/Title Date

ILLINOIS STATE BOARD OF EDUCATION SEXUAL MISCONDUCT DISCLOSURE TEMPLATE FOR APPLICANT

Instructions to Applicant: To help protect students and children against the threat of sexual misconduct, Illinois law (105 ILCS 5/22-94) requires that we conduct a sexual misconduct background check on certain applicants for hire. Therefore, you are required to complete this standardized form, which is based on a template developed by the Illinois State Board of Education (ISBE). You will be required to provide the names, contact information, and other relevant information related to your current/former employer(s) on a separate form, also based on a template developed by ISBE. You will complete one such form for each current/former employer for whom you held a position involving direct contact with children or students.

You must complete this form promptly and return it to (the hiring entity). A copy of this form will be retained by (the hiring entity), but the information provided on this form shall not be deemed a public record.

Section 1: Applicant Information

Name: (First, Middle, Last):	Any Former Names by Which Applicant Has Been Identified:
Date of Birth:	Last Four Digits of Social Security Number:
IEIN (if applicable):	Email:
Street Address:	City, State, ZIP

Section 2: Questionnaire

For purposes of the three questions below, the term "sexual misconduct," as defined in 105 ILCS 5/22-85.5 (sexual misconduct), means any act, including, but not limited to, any verbal, nonverbal, written, or electronic communication or physical activity that (1) you committed as an employee or agent of a school district, charter school, or nonpublic school during which time you engaged in or had the possibility of engaging in the care, supervision, guidance, or control of or routine interaction with students; and (2) was directed toward or with a student to establish a romantic or sexual relationship with the student. Such an act includes, but is not limited to:

1) A sexual or romantic invitation;
2) Dating or soliciting a date;
3) Engaging in sexualized or romantic dialog;
4) Making sexually suggestive comments that were directed toward or with a student;
5) Self-disclosure or physical exposure of a sexual, romantic, or erotic nature; and
6) A sexual, indecent, romantic, or erotic contact with the student.

1.	Have you ever been the subject of an allegation of sexual misconduct? Note: Check "No" if an investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated.	[ ] Yes [ ] No
2.	Have you ever been discharged from, been asked to resign from, resigned from, or otherwise been separated from any employment; been disciplined by an employer; or had an employment contract not renewed due to an adjudication or finding of sexual misconduct, or while an allegation of sexual misconduct against you was pending or under investigation? Note: Check "No" if an investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated.	[ ] Yes [ ] No
3.	Have you ever had a license or certificate suspended, surrendered, or revoked; or had an application for licensure, approval, or endorsement denied due to an adjudication or finding of sexual misconduct or while an allegation of sexual misconduct against you was pending or under investigation? Note: Check "No" if an investigation resulted in a finding that the allegation was false, unfounded, or unsubstantiated.	[ ] Yes [ ] No

Section 3: Applicant Certification

I have read and understand the contents of this Sexual Misconduct Disclosure Form. I also understand that completion of this form does not preclude the hiring entity from performing other background checks (such as reference checks, criminal history background checks, and the like) in accordance with the hiring entity's policy and/or as required by state statute for a particular position. I understand and agree that any false information I provide on this form or any willful failure to disclose information required on this form shall subject me to discipline, up to and including termination or denial of employment. By signing this form, I certify that the statements made in this form are correct, complete, and true to the best of my knowledge and I swear or affirm that I am not disqualified from employment.

Signature Printed Name Date

Catholic Diocese of Rockford

Employment Authorization Form

Please be advised that no one may offer a paid position to any individual without the advance approval of Bishop David J. Malloy.

From: Parish/School/Diocesan Agency: _____ No. _____ City: _____

Date: _____

I hereby request permission to fill the following position:

Position: _____

Name of possible Employee: _____
(Please note a name must be submitted for approval.)

This is a: ☐ New Position ☐ Replacing an Existing Position

If replacing an existing position, name of Employee being replaced: _____

If it is a new position, please explain the necessity of the position. If replacing an existing position, please explain why you cannot fulfill the duties of that position with existing personnel.

_____

_____

_____

Intended salary offer: $_____ This position requires _____ hours per week.
(This may be a range, e.g., $13 - $14 per hour, or $27,040.00 to $29,120.00 per year, etc.)

Will this person also work at another Diocesan Office? ☐ Yes, at _____ ☐ No

Criminal background check on this Employee completed; no issues indicated: ☐ Yes ☐ No
(Attach completed background check results; also fingerprint results for school employees)

Is this a contract position? ☐ Yes ☐ No

Is a Teaching Waiver required? ☐ Yes ☐ No

Has Faith's Law form been completed? ☐ Yes ☐ No
(For All School Employees)

Employment start date: _____

Submitted by: **(Please note: Requests for hiring parish employees must be submitted by the Pastor or Parochial Administrator; school employees by the Principal or Superintendent, and diocesan agency employees by the Department Director.)**

_____ _____ _____
Signature Printed Name Date

To submit form, please email to: Coco Zeman, Assistant to Bishop David J. Malloy
czeman@rockforddiocese.org

Or you may fax to: (815) 399-4769

Revised 02August2024/cz

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

REPORT OF TUBERCULOSIS SCREENING

DATE: ____/____/____

Name: _____ DOB: ____/____/____

The above named individual has been evaluated by _____.
(Name of Health Dept/Facility)

- ☐ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB, or known recent contact exposure.
- ☐ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.
- ☐ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.
- ☐ The individual had a chest x-ray on ____/____/____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Public Health Nurse or Physician Signature:

_____ Date: ____/____/____

DIOCESE OF ROCKFORD
Department of Educational Services

STATEMENT of GOOD HEALTH

Illinois School Code (105 ILCS 5/24-5) requires that new employees show evidence of physical fitness to perform duties assigned and freedom from communicable disease. A TB test is also required for employees in a school that has preschool or kindergarten. This requirement is at the employee's expense.

Employee's Name: _____ Position: _____

Statement of Good Health

I, _____, a health care provider (physician, physician
(Health Care Provider Name – **printed)**

assistant, or nurse practitioner) licensed in Illinois or any other state to practice medicine in all its branches, hereby certify that I examined the above-named person on _____
(Date)

and that he/she can perform the essential functions and duties of his/her position with or without reasonable accommodations, and that at this examination he/she is free from communicable disease.

A TB test was performed at this time. Yes_____ No_____

_____ _____
(Health Care Provider Signature Required) (Date signed)

_____
(Health Care Provider Street Address, City/State/Zip)

_____
(Health Care Provider Phone)

Please return this form to the principal of the school at which you are employed.

3/26/2019

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		
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		12. Day-care or nursery school record		

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

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.

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

2026

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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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 unless otherwise noted.

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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . 4 $ _____

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

a **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . 1a $

b **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . 1b $

c **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 1c $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . 2 $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

a Enter $6,000 if you are age 65 or older before the end of the year . . . . . 3a $

b Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . 3b $

4 Add lines 3a and 3b. Enter the result here . . . . . 4 $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . 5 $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

a **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . 6a $

b **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . 6b $

c **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . 6c $

d **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . 6d $

e **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . 6e $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . 7 $

8 **Limitation on itemized deductions.**

a Enter your total income . . . . . 8a $

b Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 8b $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . 9 $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . 10 $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . 11 $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . 12 $

13 Add lines 11 and 12. Enter the result here . . . . . 13 $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . 14 $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . 15 $

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	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

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.

AUTHORIZATION AGREEMENT FOR AUTOMATIC DIRECT DEPOSITS

You must complete this form to add, change or delete direct deposit information. Do not close an account unless you cancel your direct deposit first. Please read this form carefully and write clearly; otherwise your direct deposit will be delayed. **For security purposes, original signed authorization forms must be submitted in person to the business manager/bookkeeper for your parish/school/agency.**

If this is a new account you must:

1) Already have the account/accounts opened and active at your financial institution.
2) Make sure your bank/credit union accepts payroll direct deposits.

* *

1. ◯ Cancel Account ◯ Change Amount ◯ New Account – attach voided check

Bank, Savings & Loan, Credit Union Name _____

Bank Routing # _____ (9 digits) Bank Acct # _____

Account type: ◯ Checking ◯ Savings

Deposit: ◯ Full Deposit ◯ Partial Deposit $ _____

* *

2. ◯ Cancel Account ◯ Change Amount ◯ New Account – attach voided check

Bank, Savings & Loan, Credit Union Name _____

Bank Routing # _____ (9 digits) Bank Acct # _____

Account type: ◯ Checking ◯ Savings

Deposit: ◯ Full Deposit ◯ Partial Deposit $ _____

* *

3. ◯ Cancel Account ◯ Change Amount ◯ New Account – attach voided check

Bank, Savings & Loan, Credit Union Name _____

Bank Routing # _____ (9 digits) Bank Acct # _____

Account type: ◯ Checking ◯ Savings

Deposit: ◯ Full Deposit ◯ Partial Deposit $ _____

* *

I authorize the Catholic Diocese of Rockford to electronically deposit my paycheck directly into my bank account. I also authorize the Catholic Diocese of Rockford to electronically withdraw from my account any sum erroneously credited to my account.

Name (please print) _____ Signed _____

Parish, Office, or School Name _____ City _____ Date _____

Diocese of Rockford - Summary of Benefits

~ As of July 1, 2025 ~

For Full-Time Employees Only (35+ hours/week):		
Benefit	**Description**	**Contact Person**
Health Care Plan [Mandatory participation. One exception: other permanent (lifetime) coverage.]	- $1,000 Deductible. Coinsurance of 10/15/20% on first $15,000 in eligible claims, then Plan pays 100%. - Optional Dependent Coverage ($808/month Pre-tax or After-tax) - Provider Networks - additional savings - Cigna Prescription Plan - Dental Plan ($50 Deductible) - Vision Coverage - Select Preventive Care	**Ins. Claim Questions: PBA** (630) 655-3755 **Premium Billing & Administration:** Courtney Rippon (815) 399-4300 Ext. 340 Benefits@rockforddiocese.org
Term Life Insurance	- $10,000 term while actively working. - Decreases at ages 65 & 70.	Same as Health Care Plan Billing & Administration
Short-term Disability	- Pays 80% of regular wages up to 3-months after 2-week waiting period.	Same as Health Care Plan Billing & Administration
Long-term Disability	- Policy through Sun Life Financial. - Pays 60% of regular wages after 3-month (90-day) waiting period.	Same as Health Care Plan Billing & Administration
Lay Pension Plan	- One year waiting period; 25 years old. - 3% of salary to 10 years. - 5% to 15 years, then 6%. - Fully vested after 7 years.	**Billing & Administration:** Charlene Croyle (815) 399-4300 Ext. 338
Vacation Days	- 60-day qualification period upon hire, pro-rated first/last calendar year. - 1 week for 1-5 complete calendar years, 2 weeks for 6 or more years. - No accumulation, see Employee Handbook for more information.	
Sick Days	- 60-day qualification period upon hire, pro-rated first calendar year. - Full-time,12-month = 10 days annually; Full-time, school year = 6 days. - No accumulation, see Employee Handbook for more information.	

For Full & Part-Time Employees:		
Benefit	**Description**	**Contact Person**
Paid Personal Time, "PPT"	- 90-day qualification period upon hire. - Pro-rated first year, based on number of hours/week. - No accumulation, see Employee Handbook for more information.	
403(b) Retirement Plan	- No waiting period. - Always 100% vested. - Employer matches 15% up to 6% of employee's salary.	**LPL Financial:** Matt Young (815) 394-1520 matthew.young@lpl.com
Social Security	- Federal Government Program	
Unemployment Insurance	- Self-insured, but administered through State Unemployment Office.	**Benefits:** Lori Glenn (815) 399-4300 Ext. 343

DIOCESE OF ROCKFORD HIPAA INSURANCE ENROLLMENT CARD

SOCIAL SECURITY NUMBER	YOUR NAME (PRINT)			☐ MALE ☐ FEMALE
	Last	First	Middle Initial	

MARITAL STATUS	HEALTH COVERAGE ELECTION	WORK LOCATION
☐ Single ☐ Divorced	☐ Single ☐ Family (see other side of card)	_____
☐ Married ☐ Widowed	☐ Medical ☐ Dental/Vision	_____

OCCUPATION	EMPLOYMENT DATE	YOUR DATE OF BIRTH	SPOUSE'S DATE OF BIRTH
	Mo____ Day____ Year____	Mo____ Day____ Year____	Mo____ Day____ Year____

LIFE INSURANCE BENEFICIARY INFORMATION - PROVIDE RELATIONSHIP

Primary Contingent

☐ I decline coverage for my dependents. If you are declining enrollment for your dependents (including your spouse) because of other health insurance coverage, you may be in the future able to enroll your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents provided you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

☐ I request coverage for my dependents and authorize the deduction from my wages to pay my share of the cost.

DATE SIGNED Mo____ Day____ Year____

X _____

(Sign above, print address below)

EMPLOYER USE ONLY

☐ New Enrollee Effective Date: _____

☐ Change Unit_____ Class _____

Reason for change: _____

Termination Date: _____

Address _____

City _____

State _____ Zip _____

FOR FAMILY COVERAGE ONLY - DEPENDENT INFORMATION

If you enroll for family coverage, please print the first name and middle initial (and last name if different from your own) along with the relationship and date of birth for each eligible dependent. You may be required to submit proof of dependent eligibility.

NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH
	Spouse		

IS SPOUSE EMPLOYED? ☐ YES ☐ NO - If yes, please provide full name, address and phone number of employer:

DOES SPOUSE HAVE GROUP COVERAGE? ☐ YES ☐ NO

CHECK COVERAGE THROUGH SPOUSE'S EMPLOYER:			
	HEALTH	☐ Single Coverage	☐ Family Coverage
	DENTAL	☐ Single Coverage	☐ Family Coverage

Does any other member of your family have other group health and/or dental coverage? If yes, please explain below:

New Health Insurance Marketplace Coverage Options

This Notice is required by Law. It is for your general information.
No action is required on your part.

General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy private individual health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage we offer to you. Please note that this notice is informational only.

What is the Health Insurance Marketplace?

For Diocesan employees not covered by the Diocese of Rockford Health Care Plan, or dependents of Diocesan employees, there is the Marketplace (also called the Exchange) designed to help you find private individual health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

How Can I Get More Information About the Health Insurance Marketplace?

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

Information About Employer-Provided Health Plan Coverage

If you decide to complete an application for coverage in the Marketplace, you will be asked for information about our health plan coverage. The information below can help you complete your application for coverage in the Marketplace.

1. General Employer Information:

Employer Name:	Catholic Diocese of Rockford
Employer Identification Number (EIN):	*360879840*
Employer address:	*PO Box 7044* *Rockford Illinois 61125*
Employer phone number:	*815/399-4300*
Who can we contact about employee health coverage at this job?:	*Benefits Coordinator*
Phone number (if different from above):	*815-399-4300 ext. 340*
Email address:	*benefits@rockforddiocese.org*

2. You may be asked whether or not you are currently eligible for our health plan coverage or whether you will become eligible for coverage within the next three months. In addition, if you are or will become eligible, you may be required to list the names of your dependents that are eligible for coverage under our health plan.

If you would like information about the eligibility requirements for our health plan, please read the eligibility provisions described in the Summary Plan Description for our health plan. You can obtain a copy of the Summary Plan Description by contacting your Employer at the phone and/or email listed above.

3. If you are eligible for coverage under our health plan, you may be required to check a box indicating whether or not our health plan meets the minimum value standard. Our health plan coverage meets the minimum value standard.

4. If you are eligible for coverage under our health plan, you may be asked to provide the amount of premiums you must pay for self-only coverage under the lowest-cost health plan that meets the minimum value standard. If you had the opportunity to receive a premium discount for any tobacco cessation program, you must enter the premium you would pay if you received the maximum discount possible for a tobacco cessation program.

If you would like information about the premiums for self-only coverage under our lowest-cost health plan, please contact Employer at the phone and/or email listed above.

5. You may also be asked whether or not we will be making certain changes to our health plan coverage for the new plan year. As usual, we will notify you about changes to our health plan coverage after we approve any such changes and inform employees about those changes at the appropriate time. If you are not sure how to answer this question on your Marketplace application, please contact the Marketplace.

Diocese of Rockford
Health Insurance Trust
555 Colman Center Drive
P.O. Box 7044
Rockford, IL 61125

(815) 399-4300
FAX: (815) 997-5225

Section 125: Pre-tax Dependent Insurance Deduction Enrollment Form

(Complete ONLY if electing Dependent Insurance)

Employee Name _____ **SS#** xxx-xx-____

Employer _____ **City** _____

This agreement conforms to a flexible compensation plan pursuant to Section 125 of the Internal Revenue Code. The purpose is to authorize the reduction in salary necessary for the employer to provide **dependent health insurance.**

By this agreement made between the undersigned employee and employer, both parties agree to the following:

- The employee agrees to have his/her compensation reduced by the current amount for dependent health insurance premium.
- As consideration for the employee's voluntary election to receive benefits in lieu of the amount described above, the employer agrees to provide dependent health insurance coverage.
- The employee further acknowledges that his/her future Social Security benefits will be reduced because of, and in direct proportion to the reduction in compensation. The employee acknowledges that he/she has been offered an opportunity to participate in a supplemental retirement program (the Diocesan 403(b) Retirement Plan) designed to replace any reduced future Social Security benefits due to participation in this Section 125 plan.
- The agreement is revocable yearly at the beginning of the plan year or in the event of a major life change, e.g., loss of job by me or my spouse, death or birth or adoption of a child, death of a spouse, or divorce.

This agreement will not affect an employee contract in any way.

Please check appropriate box:

☐ Yes, I elect to participate in the Section 125 Plan.

☐ No, I do not wish to participate in the Section 125 Plan.

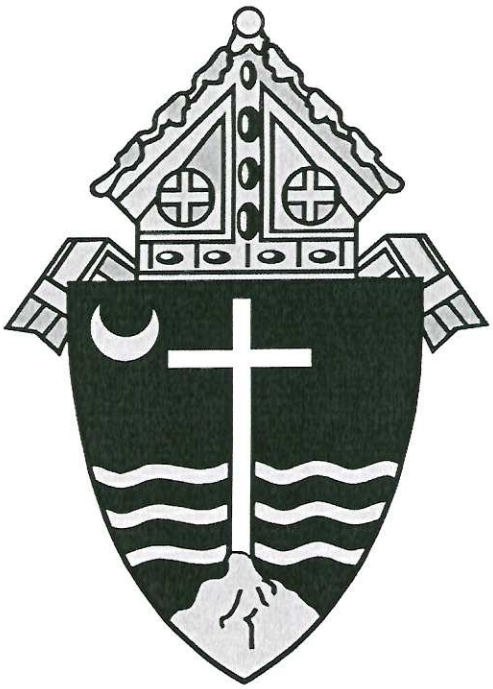
_____ _____

Employee Signature Date

Keep completed form in employee's personnel file.

Send copy with required health insurance forms to:
Health Insurance Office
Diocese of Rockford
PO Box 7044
Rockford IL 61125

The Catholic Diocese of Rockford



Lay Employee Pension Plan

Summary Plan Document

Revised April 15, 2024

Introduction

The Catholic Diocese of Rockford Lay Pension Plan was created effective October 1, 1974. It covers regular full time lay employees of the Catholic Diocese of Rockford. The Plan is funded entirely by employer contributions. Employees do not contribute to the Plan.

The Plan was created with the intention that it continue indefinitely. However, the Catholic Diocese of Rockford has the right to terminate, modify, alter or amend it; or to merge or consolidate it with any other plan.

The Plan was created to assist covered employees in financial preparation for retirement. The combination of the Plan's benefits and Social Security (funded by matching employee and employer contributions under the Federal Insurance Contribution Act (FICA) will provide a base for planning a comfortable retirement. The 403(b) Retirement Plan, provided under a program separate from this Plan can be an excellent means to supplement the Plan's benefits and should be considered by those interested in tax-advantaged retirement savings.

This is a summary plan description of The Catholic Diocese of Rockford Lay Pension Plan. It is not the official Plan document and cannot be relied upon for definitive answers to all questions. A copy of the official document is available for inspection by any employee or his/her representative during regular business hours at the Diocesan Lay Pension Office of the Diocese located at 555 Colman Center Drive, Rockford, Illinois.

In any conflict between this summary and the official Plan document, the official Plan document will control.

Eligibility

An employee becomes eligible to be a participant in the Plan when he/she completes 12 months of continuous service provided he/she is age 25 or older.

Participation commences automatically unless the employee elects not to become a participant. An election to decline participation must be submitted to the Plan Administrator in writing at least 30 days prior to the date participation otherwise would commence. An employee who declines participation may revoke this decision and become a participant on a subsequent January 1. Revocation must be in writing and delivered to the Plan Administrator at least 30 days prior to the January 1 on which it is to take effect.

An employee who is a participant may elect to discontinue participation for any Plan year. An election to discontinue participation must be submitted to the Plan Administrator in writing at least 30 days prior to January 1.

Contributions

Employer contributions made to the Plan on a participant's behalf are as follows:

a) less than 10 years of full-time employment ..... 3% of gross salary

b) 10 to 15 years of full-time employment ..... 5% of gross salary

c) more than 15 years of full-time employment ..... 6% of gross salary

However, no contributions are made for a participant who is on a leave of absence or who has elected not to participate.

Employees do not contribute to the Plan.

Benefit Accumulation

Contributions to the Plan are held in a trust fund that is invested under the supervision of the Trustees. The trust fund is invested as individual accounts. Contributions are credited to the participant's account, and, daily, earnings are credited to his/her account.

Vesting

If a participant ceases to be an employee for reasons other than death or retirement at a normal, early, or postponed retirement date, and if he/she has fewer than 7 full years of continuous service when his/her employment terminates, he/she will forfeit a portion of his/her account. The portion of his/her account that he/she does not forfeit is referred to as the vested portion of his/her account. The portion vested depends on the number of his/her full-time years of continuous service as shown on the following table.

A participant's account is fully (100%) vested if his/her employment terminates because of death or because of retirement at normal, early, or postponed retirement age.

Full Years of Continuous Service	Portion Vested	Portion Forfeited
Less than 3	none	100%
3	20%	80%
4	40%	60%
5	60%	40%
6	80%	20%
7	100%	none

Forfeitures

Forfeited pension benefits may be used as administrative fees and/or remain in the Pension Plan portfolio to be reallocated to the pension accounts of the other employees.

In-Service Transfer

Effective July 1, 2014, a full or partial in-service transfer is available to an employee who is at least age 62 and is fully vested. In-service transfers are limited to once per quarter and must be a tax deferred rollover to an Eligible Retirement Plan (i.e. IRA).

Distribution of Accounts

Generally, a participant's account becomes distributable on his/her distribution date (i.e., his/her normal retirement date unless an early, disability, or postponed retirement date applies to him/her). However, if a participant dies prior to his/her distribution date, his/her account becomes distributable to his/her beneficiary at the time of his/her death.

Distribution can only be made in a lump sum to a qualified IRA, participant or beneficiary.

The federal law governing the Plan requires the distribution of benefits begin April 1 of the calendar year following the calendar year in which the employee attains age 70½. In the case of a church plan, the required beginning date shall be the later of the date determined under the preceding sentence, or April 1 of the calendar year following the calendar year in which the employee retires. Accordingly, the Plan provided that distribution of a participant's account begin the later of April 1 following the close of the calendar year in which a retired person reaches age 70½, or April 1 following the close of the calendar year in which a person retires.

An employee, upon termination of employment, is required to complete the *Notice to Administrator of Participant's Leaving Plan* form. This form should be completed by all participants leaving the Plan as a result of termination, retirement, or disability. Upon death, a copy of the Death Certificate should be attached to the form. The completed form should be forwarded to the Diocesan Lay Pension Office.

A portion of a participant's account may be forfeited under certain circumstances (as described under "Vesting" below), in which case only the vested portion of his/her account becomes distributable.

Beneficiary Designation

The participant shall have the right to change the designated beneficiary of the Plan at any time or times by filing a new designation with the Plan Administrator on the form provided, but such designation shall be effective and acted upon only if received by the Plan Administrator prior to the participant's death.

Loans and Fees

A participant may not borrow from the Plan nor may his/her interest in the Plan be pledged as collateral for a loan from another party.

Participants pay an ongoing administration fee of 0.35% of assets held in each participant's Retirement Plan account. This fee is withdrawn directly from each participant's Retirement Plan account.

There are no termination or asset transfer charges imposed when a participant withdraws or rolls over assets in a Retirement Plan account.

Definitions

These terms are defined as follows for purposes of this summary plan description.

"Beneficiary" – the person or persons designated by a participant to receive his/her benefits under the Plan should he/she die before all of his/her benefits have been paid out. Corporations and trusts, as well as natural persons, may be a Beneficiary. The designation must be made in writing. A form may be obtained from the employer or by contacting the Diocesan Lay Pension Office.

"Continuous Service" – a period of service to an employer without break. Continuous Service is measured from last date of hire. Transfer of employment from one diocesan employer to another does not cause a break in service, provided service to the new employer commences within a reasonable time after service to the prior employer ceases. Generally, if a break in service does not exceed the period of a participant's full-time employment, this condition is met. Further, a leave of absence granted by an employer is included in Continuous Service if the leave is granted under Plan rules. Generally, Plan rules permit leaves of absence for required service in the Armed Forces, sickness or disability, and similar purposes, provided the leave does not extend for more than 24 consecutive months, or, in the case of required service in the Armed Forces, does not extend for more than 6 months beyond discharge from Armed Forces service.

"Distribution Date" – the date of payment of a participant's benefits. Generally, a participant's Distribution Date is his/her normal retirement date; unless an early retirement, disability, or a postponed retirement date applies. Distributions of Participants' accounts are usually made within 60 days after the close of the quarter and contributions are collected. Employers are required to remit contributions to the Plan by the end of the month following the quarter ending date.

"Earnings" – a participant's gross compensation reported on his W-2 without regard to deductions for a 403(b) Retirement Plan account.

"Employee" – a regular full-time lay employee of a Diocesan employer. Regular full-time employment is 35 hours or more per week for the normal work year.

"Employer" – those parishes, schools, and agencies of the Catholic Diocese of Rockford.

"In-Service Transfer" – a Qualified Employee can transfer a portion or all of his or her fully vested balance in the pension plan to an Eligible Retirement Plan of the employee's choosing. A Qualified Employee for this purpose is one who is at least age 62 at the time of transfer and is fully vested with the Diocese of Rockford Lay Employee Pension Plan. A Qualified Employee may request an in-service transfer no more than once per calendar quarter. The transfer must be a tax-deferred rollover to an Eligible Retirement Plan as defined in the Plan document, §6.7(c).

"Participant" – an employee who has met the eligibility requirements of the Plan and who is accruing benefits under the Plan.

"Plan" – the Catholic Diocese of Rockford Lay Pension Plan.

"Plan Year" – a 12-month period beginning January 1.

"Summary" – this summary plan description of the Plan.

"Trustees" – collectively, the persons authorized to manage the Plan. The Trustees are the Bishop or his delegate, the President of the Priests' Senate, the Vice President of the Clergy Relief Society, the Representative of Women Religious, and from five to nine representatives appointed by the Bishop.

Questions about eligibility and provisions of the plan should be directed to:

Matt Young
LPL Financial
2807 Charles Street
Rockford, IL 61108
Phone: (815) 394-1520
Toll Free: (877) 621-2784
Fax: (815) 394-3909
e-mail: matt.young@lpl.com

All transfer and withdrawal forms can be mailed, e-mailed or faxed to Matt Young or Security Benefit directly. Forms demanding medallion signatures are required to be mailed.

Mail to:
Security Benefit Retirement Plan Services
P.O. Box 219141
Kansas City, MO 64121-9141

Phone: (800) 747-3942
Fax: (816) 701-7626

For Expedited or Overnight delivery:
Security Benefit Retirement Plan Services
430 W 7th Street STE 219141
Kansas City, MO 64105-1407

Catholic Diocese of Rockford

403(b) Retirement Plan

Effective April 15, 2024

INTRODUCTION

The Catholic Diocese of Rockford adopted a "single provider" format for the 403(b) Retirement Plan effective June 1, 2008. The Plan was created to encourage priests, deacons, and lay employees to save a portion of their current earnings to build a personal retirement fund to supplement Social Security benefits and any applicable pension benefits.

ELIGIBILITY

All priests, deacons and lay employees who receive compensation for their services to diocesan organizations, whether part-time or full-time, may participate in the Plan through voluntary salary deferrals. Eligibility commences with the date of hire. Employer matching contributions also become eligible immediately following the date of hire.

EMPLOYEE CONTRIBUTIONS

- Contributions are automatically deducted from employee paychecks.
- Contributions are pre-tax (unless a participant elects a Roth Plan). Contributions are deducted before paying Federal and Illinois income taxes. Pre-tax investments grow tax-deferred and are taxed only upon withdrawal from the Plan.
- Contributions are post-tax if an employee elects a Roth Plan. Earnings on post-tax Roth contributions will not be taxed if certain conditions are met when a participant withdraws funds from the Plan.
- Employees may contribute up to 100% of their compensation as allowed under the IRS Code.

EMPLOYER CONTRIBUTIONS

Diocesan employers match employee contributions each payroll period equal to 15% of the first 6% of compensation that an employee contributes to the plan.

Example: An employee earns $30,000 annually and elects to defer 10% of his or her compensation to the 403(b) Retirement Plan. Since the employer matches to a maximum of the first 6% of compensation, the match is computed as follows:

$30,000 earnings x 6% maximum
x 15% match = $270.

REMITTANCE OF CONTRIBUTIONS

Employee and Employer contributions are remitted to Security Benefit Life by the diocesan payroll office by the end of the month following the month of contribution.

VESTING

Employee and employer contributions to the 403(b) Retirement Plan are 100% vested at all times. This means the value of all contributions made by the employee and the match from the employer, together with accumulated earnings, are payable to the employee upon retirement or termination of employment regardless of the years of service.

INVESTMENT OPTIONS

- Employees may choose to invest from among all of the funds offered by Security Benefit Life including 15 different "target portfolios" designed to fit different investment strategies.
- Employees may change their investment mix at any time.

. . . continued on next page.

WITHDRAWALS AND LOANS

Participants in the 403(b) Retirement Plan have the following options for withdrawals or loans:

- Hardship withdrawals. When certain emergencies occur, such as extended illnesses or catastrophic casualty losses, participants may withdraw funds from their Retirement Plan accounts.

- "In-service" withdrawals. These are withdrawals made by participants while actively employed within the diocese, and who have attained the age of 59 ½ years or older.

- Loans. Participants may borrow from their Retirement Plan accounts subject to interest charges and a repayment plan. In addition to interest charges, participants who borrow from their Retirement Plan accounts pay a one-time loan origination fee of $50 and a quarterly administration fee of $12.50 for each outstanding loan.

FEES

- Participants pay an ongoing administration fee of 0.35% of assets held in each participant's Retirement Plan account. This fee is withdrawn directly from each participant's Retirement Plan account.

- There are no termination or asset transfer charges imposed when a participant withdraws or rolls over assets in a Retirement Plan account.

ROLLOVERS TO THE RETIREMENT PLAN

Participants may roll over account balances from another eligible retirement plan, including Individual Retirement Accounts (IRAs), into the 403(b) Retirement Plan.

NORMAL DISTRIBUTIONS

Participants may request a distribution of their Retirement Plan account balances upon retirement, termination of employment, or permanent disability. Distributions to participants may be taxable. Participants may postpone current income tax liability by rolling over Retirement Plan account balances to another tax-qualified retirement plan or Individual Retirement Account (IRA). The IRS also has minimum distribution requirements depending upon the age of the participant. On all these issues, please consult your tax advisor before making decisions.

ACCOUNT INFORMATION

Participants receive quarterly statements mailed directly to their home address. They may access information or make changes to their Retirement Plan accounts at: www.securityretirement.com.

Questions about enrolling, and provisions of the plan should be directed to:

Matt Young
LPL Financial
2807 Charles Street
Rockford, IL 61108
Phone: (815) 394-1520
Toll Free: (877) 621-2784
Fax: (815) 394-3909
e-mail: matt.young@lpl.com

All transfer and withdrawal forms can be mailed, e-mailed or faxed to Matt Young or Security Benefit directly. Forms demanding medallion signatures are required to be mailed.

Mail to:
Security Benefit Retirement Plan Services
P.O. Box 219141
Kansas City, MO 64121-9141

Phone: (800) 747-3942
Fax: (816) 701-7626

For Expedited or Overnight delivery:
Security Benefit Retirement Plan Services
430 W 7th Street STE 219141
Kansas City, MO 64105-1407

Employee:_____

Date: _____

Diocese of Rockford

Emergency Contact Numbers

1. Name: _____ Relationship: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Preferred number: (cell home work) ( ) _____
   Please circle

   Secondary number: (cell home work) ( ) _____
   Please circle

2. Name: _____ Relationship: _____

   Address: _____

   City: _____ State: _____ Zip: _____

   Preferred number: (cell home work) ( ) _____
   Please circle

   Secondary number: (cell home work) ( ) _____
   Please circle

EMPLOYEE HANDBOOK
RECEIPT AND ACKNOWLEDGEMENT

I, _____, acknowledge that I have received the
(Name of Employee)
"Employee Handbook" of the Catholic Diocese of Rockford. I agree that I will read and abide by the provisions of the Employee Handbook as an employee of the Diocese.

I also acknowledge that this Handbook is not a contract, and that the Diocese has the discretion to revise this Handbook. I also understand that my employment is "at will" and, therefore, either the Diocese or I may discontinue the employment relationship at any time and for any reason.

I understand that my employment with the Diocese makes me a representative of the Catholic Church, whether at work or away from work. I agree to abide by the faith and moral teachings of the Catholic Church at all times, and I understand that if I engage in activity contrary to same, I am subject to being terminated.

Lastly, I acknowledge that the "Employee Handbook" that I have received this date replaces all prior employee handbooks or manuals that I may have received during my employment with the Diocese. I agree that those former employee handbooks or manuals are no longer in force or effect.

_____ _____
Employee Date

_____ _____
Name of Parish, School or Diocesan facility City

Rev. 1/1/2024

CATHOLIC DIOCESE OF ROCKFORD
Payroll Addition, Change, or Termination

Parish/Agency Name _____
Parish/Agency Number _____

Employee Addition ☐→ First Day Worked _____
Employee Change ☐→ Pay Date Effective _____
Employee Termination ☐→ Last Day Worked _____

Employee Social Security No. _____ - _____ - _____
Employee File Number _____

Employee Name _____ Date of Birth _____
Last, First, Middle Initial (MUST agree with Social Security card)

Employee Address _____ Male ☐ Female ☐

City, State, Zip + 4 _____ Full ☐ or Part-time ☐

GENERAL LEDGER DISTRIBUTION:

Dept.	Account #	Per Cent
____	_____	_____
____	_____	_____

Job Title _____

Supervisor _____

PAY & TAX INFORMATION:

Pay Type:

** ☐ Hourly $_____per hour/day
per day rate based on _____ hours*

** ☐ Salary $_____per pay
based on _____ hours per week*

Pay Frequency:

Weekly ☐
Bi-Weekly ☐
Semi-Monthly ☐
Monthly ☐

Federal & State Withholding: **Please Submit W-4 Forms**

State Name _____ (If other than Illinois)

Other Locations Working/Worked in the Diocese:

_____

_____

Annual salary per year or contract year $ _____, paid over _____ pay periods, based on _____ hours per week. *

DEDUCTIONS FROM PAY:

Description	Amount per pay	or	Per Cent	Limit	Pre-Tax
_____	$_____		_____	$_____	☐
_____	$_____		_____	$_____	☐

Authorization to hire obtained from Bishop ☐

***The hours worked per week are mandatory for salaried employees.**
****All pay rate changes must be approved.** → → →

****Approved By:** _____

Revised 2/2026

The Payroll Office assumes the responsibility only for the accuracy of processing the data received.