NEW HIRE CHECKLIST
GOVERNOR'S OFFICE OF ELDERLY AFFAIRS

A. FORMS TO BE COMPLETED BY EMPLOYEE - MANDATORY

_____ Application for LASERS retirement system (Optional if transferring from another state agency; enter "NO CHANGE" on form and sign.)
_____ Lasers Beneficiary Form
_____ Lasers Benefit Forfeiture
_____ Appointment affidavit SF-13
_____ Deferred Compensation enrollment (optional)
_____ Direct Deposit Enrollment Authorization Main Bank. EMPLOYEE MUST COMPLETE THIS FORM AND ATTACH A VOIDED CHECK. (If transferring from another state agency can enter "NO CHANGE" on form and sign.)
_____ Emergency contact information
_____ Employment eligibility verification I-9 form. MUST HAVE COPIES OF DOCUMENTS ATTACHED.
_____ Tax form W-4 federal taxes (Optional if transferring from other state agency. Can write "NO CHANGE" on form.)
_____ Flexible spending accounts enrollment form (optional)
_____ Insurance - Office of Group Benefits enrollment/change form MUST BE COMPLETED BY ALL NEW HIRES.
- If not already enrolled in Group Benefits, OBG will request proof of coverage for PORTABILITY.
- IF NO COVERAGE IS SELECTED, COMPLETE SECTION I. WAIVER OF COVERAGE. Employee keeps gold copy.

_____ Louisiana Second Injury Fund E-2 form. Employee must complete and place in sealed envelope marked "CONFIDENTIAL."
_____ Medicare tax eligibility form
_____ Planned working time change notification
_____ Prior state service verification. Employee must review and sign EMPLOYEE NOTIFICATION FORM and CS02 to verify.
_____ Recoupment of Overpayments
_____ Tax form L-4 state taxes (Optional if transferring from other state agency. Can write "NO CHANGE" on form.)
_____ Statement Concerning Your Employment in a Job Not Covered by Social Security
_____ Statement of Agreement RE: Compensation for Overtime Work
_____ Driver Authorization Form
_____ Transcript
_____ Review overtime Rule 21.12(Check with transferring agency to make sure leave is canceled or paid out before transfer)
_____ Newly Hired Employee Offer of Coverage
_____ Online W-2 Selection
_____ OTS User Agreement
_____ Galvez Parking Garage Access Form
_____ GOEA Telework Agreement Form

B. INFORMATION TO REVIEW WITH NEW EMPLOYEE

_____ Change in information to be reported to HR
_____ Check issuance
_____ Dress code
_____ Earning of annual/sick/compensatory (K) leave
_____ Holidays
_____ LEO self-service
_____ Performance Adjustments increase
_____ Parking

_____ Performance Evaluation (PES) system

_____ Personnel manual (have employee sign acknowledgement form and send it to HR.)

_____ Political Activity policy (employee must receive copy)

_____ Position title and starting salary

_____ Probationary period (If transferring in from another state agency with permanent status, this does not apply.)

_____ Safety manual (have employee sign acknowledgement form and send it to HR.)

_____

SF-13 (R 5-03)

APPOINTMENT AFFIDAVITS

IMPORTANT: Please read the following appointment affidavits. Before swearing to these affidavits, make sure you understand the fully. It is the responsibility of the employing agency to determine any change in employment status since the applicant filed the original pre-employment application.

APPOINTEE	AGENCY /DIVISION
PRESENT STREET ADDRESS	PLACE OF EMPLOYMENT
CITY/ STATE/ZIP	DATE OF BIRTH

A. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU BEEN INDICTED OR CONVICTED OF ANY LAW VIOLATION (excludes minor traffic violations)? ☐ YES ☐ NO
IF YES, GIVE DETAILS:

DATE	LOCATION	CHARGE

DISPOSITION

B. SINCE YOU FILED THE APPLICATION RESULTING IN YOUR APPOINTMENT, HAVE YOU RESIGNED OR BEEN DISCHARGED AS A RESULT OF MISCONDUCT? ☐ YES ☐ NO

IF YES, GIVE DETAILS:

C. DO YOU NOW HOLD OR ARE YOU A CANDIDATE FOR AN ELECTIVE PUBLIC OFFICE? ☐ YES ☐ NO

D. AS REQUIRED BY LOUISIANA REVISED STATUE 42:52

Do you solemnly swear (or affirm) to support the Constitution and laws of the United States and Constitution and laws of this State, and faithfully and impartially discharge and perform all of the duties incumbent upon you as a State employee according to the best of your ability and understanding? ☐ YES ☐ NO

DATE	SIGNATURE OF APPOINTEE	SOCIAL SECURITY NO.

☐ REVISION
☐ NEW REQUEST

GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
PLANNED WORKING TIME CHANGE NOTIFICATION

Employee Name	
Employee Personnel Number	

I request to set my planned working time schedule as follows **Effective Date:** _____

Option 1 Five 8 hours workdays M-F *Schedule between 7 am- 7 pm		Time In _____ Time Out _____ *Include 30 min lunch break
Option 2: Four 10 hour work days M-F Choose a requested off day and an alternate day. ⇒ *Schedule between 6 am- 7pm	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday Alternate Day _____	Time In _____ Time Out _____ *Include 30 min lunch break
Four 9-hour and One 4-hour work day Choose requested 4-hour work day and alternate day. Schedule between 6 am- 7pm	☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday Alternate Day _____	Time In _____ Time Out _____ *Include 30 min lunch break

☐ APPROVED _____

☐ APPROVED WITH CHANGES _____

APPROVED BY MANAGER _____ DATE _____

- I acknowledge that I am aware that changes to working times or schedules shall be submitted at the end of each quarter (March, June, September, or December.) Requests based on medical needs may be submitted at any time although additional documentation will be required.

_____ DATE _____

Employee's Signature

HRM 1020
Revised 05/2021
PAF 1024

MEDICARE TAX ELIGIBILITY FORM

Effective April 1, 1986, all new state employees will be subject to pay 1.45% of their gross salary for the Medicare tax. This will be in addition to their other deductions such as retirement and federal and state tax.

I have read the information above and understand that since:

_____ I have been continuously employed in state government since prior to April 1, 1986. I am not required to pay this tax.

_____ I have not been continuously employed in state government since April 1, 1986. I am required to pay this tax.

_____ _____

Employee Signature Date

Social Security Administration

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ **Date** _____

Governor's Office of Elderly Affairs

PRIOR STATE SERVICE QUESTIONNAIRE INFORMATION

The purpose of this form is to obtain information for determining the specific amount of State service to your credit. This information is needed for several reasons:

- One example of its use is that the amount of sick and annual leave that you accrue is determined by your length of State service.
- Another example is that the length of State service is used to determine the order of implementation of layoff and layoff avoidance measures.

In order to determine your length of State service, it will be necessary for you to furnish us with the information requested on the attached form. The following information should be helpful to you when completing this form.

The following examples are considered State service for leave accrual purposes:

1. Serving in any ***classified position.***
2. Serving in any ***unclassified position.*** Examples of creditable unclassified service would be:
   a. Employees of state schools: teachers, substitute teachers, teachers' aides, lunchroom workers and school bus drivers.
   b. All employees of parish and State school boards.
   c. State board or Commission members.
   d. Heads of departments appointed by the Governor.
   e. Students who were employed in accordance with Civil Service Rules 1.5.1 and 4.1(d)2.

These are the most common examples considered as State service for the purpose of layoff and layoff avoidance measures and are not all inclusive:

1. All time spent on any type of classified appointment prior to January 1, 1983.
2. All time spent on any type of unclassified appointment prior to January 1, 1983. See above examples 2 a-e.
3. Classified State service obtained after 1, 1983, on probational, job and permanent appointments that were not part-time intermittent and on restricted or provisional appointments that were converted to probational or job appointments and were not part-time intermittent.

It is the policy of the HR Office to verify and credit to your leave record any prior ***classified*** state service. However, student or other unclassified employment with a public school or state university must be verified by you. It is ***your responsibility*** to provide the HR Office with certification from the applicable school or school board of your total time worked before credit can be shown on your record. ***If employment was not full-time, verification must be in number of hours worked.***

When completing the attached questionnaire, list each state agency, including this one, where you have been employed and length of service with each agency. Start with your most recent employment and work back.

After completing the questionnaire, please sign it.

GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
PRIOR STATE SERVICE QUESTIONNAIRE

PRINT ALL INFORMATION

LAST NAME, FIRST NAME, MI JOB TITLE NAME OF WORK UNIT

MILITARY SERVICE Dates: (if applicable) From To

Name of State Agency *If you have no prior state service, write NONE on the form and sign it.*	Employment Status (Permanent, Job Appt., Restricted Appt., Unclassified, etc.)	Employment Date mm/dd/yyyy		Full Time (Worked at least 40 hrs/wk)	Part Time (list # of hours worked per week)	Leave Without Pay mm/dd/yyyy		HR Office Use Only Total Service				
		From	To			From	To	Count For Service	Count for Leave	Yrs	Mths	Days
								☐	☐			
								☐	☐			
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								☐	☐			
								☐	☐			
								☐	☐			

THE EMPLOYMENT INFORMATION LISTED BY ME IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Personnel No. Employee Signature Date

FOR HUMAN RESOURCES USE ONLY

ASD ALSD VERIFIED BY DATE ISIS INPUT DATE

RECOUPMENT OF OVERPAYMENTS:

It shall be the policy of the Governor's Office of Elderly Affairs to notify employee (s) when an overpayment has occurred and recoupment must take place.

Written notification will give the reason why the overpayment occurred and specify how/when the agency will start the recoupment procedure.

I have read the above statements and understand if an overpayment is generated in my bi-weekly pay, recoupment by the agency will take place.

_____

NAME

_____

TITLE/UNIT

_____

DATE

STATE CIVIL SERVICE

STATEMENT OF AGREEMENT OR UNDERSTANDING
Compensation for Overtime Work

I, _____, understand that agencies of the State of Louisiana have the option of granting compensatory leave for overtime hours worked.

NON-EXEMPT EMPLOYEES: In cases where the Fair Labor Standards Act applies, such leave will be credited to non-exempt employees at the rate of one and one-half hour for each hour worked. For overtime hours worked during weeks when leave is taken (with or without pay), or when holidays are observed, the agency may opt to use straight-time cash payments or hour-for-hour compensatory leave to compensate non-exempt employees, in accordance with the Rules of the Department of State Civil Service.

EXEMPT EMPLOYEES: Agencies have the option of granting no overtime compensation at all to exempt employees; but if the agency chooses to compensate exempt employees for overtime, the agency may choose to compensate such employees with compensatory leave rather than cash payment.

PAYMENT OF COMPENSATORY LEAVE UPON SEPARATION:

* NON-EXEMPT EMPLOYEES: I also understand that non-exempt employees shall be paid upon separation for any time and one-half compensatory leave earned for overtime, as required by the Fair Labor Standards Act. Other straight, hour-for-hour compensatory leave shall be paid upon separation in accordance with Civil Service Rule 21.12.

* EXEMPT EMPLOYEES: Compensatory leave credited to exempt employees may or may not be paid upon separation in accordance with the applicable Civil Service Rules. Any such compensatory leave that is not paid, shall be cancelled, in accordance with the applicable Civil Service Rules.

I have read the above and agree to accept compensatory leave as compensation for overtime work.

Printed or Typed Name: _____

Signature: _____ Date _____

GOEA Employee Emergency Notification

Date: _____

New ___ Revised ___

Louisiana Governor's Office of Elderly Affairs
Galvez Building
602 North 5th Street, 4th Floor
Baton Rouge, Louisiana 70802
Phone: 225-342-7100
Fax: 225-342-7133
www.GOEA.Louisiana.Gov

Employee Name:	
Title:	
Address:	
City:	
Zip Code:	
Home Phone:	
Cell Phone:	
Employee Supervisor:	
Name:	
Title:	
Contact Number:	

For emergency purposes only, please list alternate staff:

Staff Name/Title	Contact Number

Person to Notify in Case of Emergency

Name (1)	
Address:	
State:	
Home Phone:	
Work Phone:	
Cell Phone:	
Relationship:	
Name (2)	
Address:	
State:	
Home Phone:	
Work Phone:	
Cell Phone:	
Relationship:	
Other Information:	

Will you need assistance going down stairs during an emergency at the Galvez Building?

Yes ___ No ___

OSUP/F12A
R 01/05/2011

STATE OF LOUISIANA
LAGOV ERP-HUMAN CAPITAL MANAGEMENT
DIRECT DEPOSIT ENROLLMENT AUTHORIZATION
MAIN BANK (PRIMARY ACCOUNT)

EMPLOYEE SSN	DEPARTMENT/OFFICE OR AGENCY
ACTION TYPE (✓ one) ☐ NEW ☐ CHANGE ☐ TERMINATE THIS OPTION	

PRIMARY ACCOUNT INFORMATION
(Main Bank)
DEPOSIT AMOUNT TO THIS ACCOUNT WILL BE EQUAL TO NET PAY LESS ANY DEPOSITS TO SECONDARY ACCOUNTS.

FINANCIAL INSTITUTION NAME	FINANCIAL INSTITUTION ROUTING (ABA) NUMBER *(Bank Key)*	
BANK ACCOUNT NUMBER	ACCOUNT NAME * (Ex: Mr. and Mrs. John Doe, John or Jane Doe, John Doe)	
ACCOUNT TYPE (✓ one) *(Bank Control Key)* ☐ **CHECKING (provide voided check or account verification) ☐ **SAVINGS (obtain account # & ABA # from financial institution)	**Account verification or completion of enrollment form by financial institution will assure the accuracy of account data: Signature from institution:_____	
	Effective Date	_____ PAYDAY
	Phone number:	

I _____ (Print full name) authorize and request the State of Louisiana to direct my net pay check to the account at the financial institution I designated above.

It is my responsibility to notify my Employee Administration Office, as appropriate, should any changes occur to account specified. Considering all above conditions are met, this authorization remains in full effect until a written, signed notification to terminate, or another signed form (OSUP/F12A) indicating termination of this option is received from me and the State of Louisiana has had reasonable opportunity to act on the termination. However, I understand and acknowledge that I am responsible for any account information indicated on this form as well as any account information that I add or any changes that I make to my accounts through Louisiana Employees Online (LEO).

For direct deposits that are affected by the International ACH Transaction (IAT) rules check one:
☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above <u>will not</u> subsequently be forwarded to a foreign financial institution.
☐ I affirm that the entire amount of the payroll direct deposits sent to my account at the financial institution designated above <u>will</u> subsequently be forwarded to a foreign financial institution.

Signature	Date	Phone number where you can be reached between 8:00 am and 4:30 pm

*Deposits can only be made to accounts that belong to you. Exceptions: Deposits can be made to the accounts of dependents or a parent/guardian when the employee is a dependent of the parent/guardian.
**Agency requirements may vary. Contact your Employee Administration office if you have any questions.

TO BE COMPLETED BY EMPLOYEE ADMINISTRATION OFFICE:

MAIN BANK	FINANCIAL INSTITUTION ROUTING (ABA) NO. (If not provided above)	
PERSONNEL AREA NUMBER	PERSONNEL NUMBER	EFT VALIDITY DATE

☐ **CHECK HERE IF SECONDARY ACCOUNT FORMS ARE ATTACHED**

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)			**Additional Information**		
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)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		6. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		7. Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,

Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	Middle Initial

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Office of Elderly Affairs
Personnel Manual
CONFIRMATION FORM

CONFIRMATION AND CONSENT FORM

OFFICE OF ELDERLY AFFAIRS

Having received a copy of the current Office of Elderly Affairs Personnel Manual, I state that I have read and understand the contents.

Signature_____Date_____

SAFETY MANUAL

I certify that I have been trained on the following OEA Safety Policies:
Blood borne Pathogens, Violence in the Workplace, Drugs Free Workplace, Sexual Harassment, Defensive Driving, General Safety Procedures and Safety Responsibilities and Assignment of Responsibilities

_____
Name

_____
Date

GOVERNOR'S OFFICE OF ELDERLY AFFAIRS
POLICY PROHIBITING SEXUAL HARASSMENT

ACKNOWLEDGEMENT AND CERTIFICATION

My signature hereon acknowledges that:

1) I received a copy of GOEA's Policy Prohibiting Sexual Harassment;

2) I read this Policy;

3) I understand the content of this Policy;

4) I agree to abide by the terms and provisions of this Policy;

5) I understand that compliance with this Policy is a condition of employment; and

6) I understand that disciplinary action, including the possibility of dismissal, will be imposed on those who violate the terms and provisions of this Policy.

EMPLOYEE SIGNATURE _____ DATE _____

EMPLOYEE NAME (PRINT) _____

HUMAN RESOUCES CERTIFICATION

My signature hereon acknowledges that:

1) I personally discussed in detail GOEA's Policy Prohibiting Sexual Harassment with the employee identified above;

2) I answered this employee's questions regarding this Policy;

3) I confirmed this employee's completion of the online training on sexual harassment provided through CPTP; and

4) I informed the employee of the consequences of violating this Policy.

HR SIGNATURE _____ DATE _____

HUMAN RESOURCES NAME (PRINT) _____

DRIVING AUTHORIZATION FORM

STATE OF LOUISIANA

DRIVER AUTHORIZATION FORM

TO BE COMPLETED ANNUALLY, UPON CHANGE OF STATE OF ISSUANCE, CLASS OF LICENSE, AND/OR DRIVING RESTRICTION CHANGE

Agency: _____
Employee Name: _____ Employee Number: _____
Immediate Supervisor: _____ Driver Training Course (MM/DD/YY): _____
Drivers License Number: _____ State of Issuance: _____

AGENCY HEAD OR DESIGNEE AUTHORIZATION

By executing this document, I have reviewed the Official Driving Record and Driver Training Course dates and have confirmed the information to be current and in accordance with the ORM Loss Prevention requirements.

My signature authorizes the aforementioned employee to drive the following on state business as required (check all that apply):

_____ STATE VEHICLE
_____ RENTAL VEHICLE
_____ PERSONAL VEHICLE

_____ _____
AGENCY HEAD (or designated individual) DATE OF AUTHORIZATION

EMPLOYEE ACKNOWLEDGEMENT/AUTHORIZATION

This is to certify that, as a condition of and if authorized to drive my personal vehicle on state business, I have and will maintain at least the minimum liability coverage as required by *LA. R.S. 32:900 (B) (2).*

I understand that the use of my vehicle on state business requires prior written authorization from my supervisor or agency head.

Further, by signing this document, I agree to notify my agency in writing should any of the following change on my license: Drivers License No., State of Issuance, Class of License or Driving Restrictions.

I authorize my agency to obtain access to my Official Driving Record (ODR) as necessary to comply with the State's Loss Prevention Program.

I affirmatively acknowledge and understand that operating a state-owned, state-rented or state-leased vehicle while intoxicated as set forth in R.S. 14:98 and 14:98.1 is strictly prohibited, unauthorized, and expressly violates both the terms and conditions of my use of said vehicle, and my employer's instructions. In the event such operation results in my being convicted of, pleading nolo contendere to, or pleading guilty to, driving while intoxicated under R.S. 14:98 or 14:98.1, I acknowledge and understand that such would constitute evidence of: (1) my violating the terms and conditions of my use of said vehicle, (2) my violating the direction of my employer, and (3) my

My signature on this document shall remain in effect until revoked by the agency or until a new form is executed.

_____ _____
EMPLOYEE SIGNATURE DATE

07/01/2012
DA 2054

ANNUAL SUPPLEMENTAL SIGNATURE PAGE

EMPLOYEE NAME:_____

DRIVERS LICENSE NUMBER:_____

DEPARTMENT/AGENCY:_____

AGENCY HEAD OR DESIGNEE STATEMENT

By executing this document, I have reviewed the following and have confirmed the information to be current and in accordance with the ORM Loss Prevention requirements:

Official Driving Record
Drivers Training Course

Further, my signature allows the aforementioned employee to drive a state vehicle, rental vehicle or personal vehicle on state business.

Agency Head (or designated individual)	*Date of Authorization*
Agency Head (or designated individual)	*Date of Authorization*
Agency Head (or designated individual)	*Date of Authorization*
Agency Head (or designated individual)	*Date of Authorization*
Agency Head (or designated individual)	*Date of Authorization*
Agency Head (or designated individual)	*Date of Authorization*
Agency Head (or designated individual)	*Date of Authorization*

(DUPLICATE SUPPLEMENTAL SIGNATURE PAGE AS NEEDED)

TAXES

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

(a) First name and middle initial | Last name | (b) Social security number

Address

City or town, state, and ZIP code

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*.

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

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

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

1. Expect to work only part of the year;

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . 2 $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

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

Single or Married Filing Separately

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

Head of Household

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

R-1300 (4/11)

LDR
Contributing to a better quality of life

Employee Withholding Exemption Certificate (L-4)

Louisiana Department of Revenue

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions. Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "*No exemptions or dependents claimed*" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "*Single*" under number 3 below, if you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "Single" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "Married" under number 3 below.

A.

Block B

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form L-4
Louisiana Department of Revenue

Employee's Withholding Allowance Certificate

1. Type or print first name and middle initial	Last name
2. Social Security Number	3. Select one ☐ No exemptions or dependents claimed ☐ Single ☐ Married

4. Home address (number and street or rural route)

5. City	State	ZIP

6. Total number of exemptions claimed in Block A	6.
7. Total number of dependents claimed in Block B	7.
8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount.	8.

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature	Date

The following is to be completed by employer.

9. Employer's name and address	10. Employer's state withholding account number

John Bel Edwards

Governor

State of Louisiana

OFFICE OF THE GOVERNOR

Office of Elderly Affairs

The Office of State Uniform Payroll (OSUP) offers **active** employees the option to self-view and print their W-2 in Louisiana Employee On-Line Services (LEO) in lieu of receiving a paper W-2 form via the United States Postal Service (USPS). OSUP is reminding **active** employees who have not elected the self-view and print option, to do so by December 31.

If you are an active employee and have already opted to self-view and print your W-2, no action is needed. It is, however, recommended that you review your record in LEO, to ensure your election was recorded and saved for future calendar years.

Participation is optional for all active employees:

- If you are actively employed and wish to take advantage of the W-2 on-line self-view and print option you must provide consent in LEO by **December 31.** W-2s will be available in LEO for viewing and printing by **mid-January**.
- If you do not provide consent by the required deadline, you revoke your consent, or you do not wish to use this service you will continue to receive a paper W-2 Form through the USPS. All paper W-2 Forms will be mailed **January 31** or the next business day if January 31 falls on a weekend.
- Once consent is given, it will remain for all future reporting periods unless you revoke the decision or separate from employment. To revoke your consent, you **must** do so in LEO by the December 31 deadline for the current reporting year.
- Employees who separate from state service do not have the option of receiving their W-2 on-line but will receive a paper W-2 through the USPS. Paper W-2 Forms will be mailed **January 31** or the next business day if January 31 falls on a weekend.

Participation is fast, easy and no cost to you:

- To provide consent, revoke consent, and view and print your W-2 you simply have to sign on to LEO using your active password. Follow the step-by-step guidelines provided to you in LEO.
- To view and print your W-2 you will need an internet connection, web browser, access to LEO with an active password and Adobe Acrobat software.
- There is no cost to you for this service; however, receiving your W-2 faster may give you a head start on completing your annual IRS tax filing and, if applicable, any refund may be received sooner.
- Once the W-2s are available in LEO (**by mid-January**), you may view and print your W-2 as often as needed at no cost to you.

Duplicate W-2 Information:

- After providing consent in LEO, an employee may still request a paper Form W-2 by contacting their agency's EA/HR Department and completing the Request for Duplicate W-2 Form, OSUP/F37.
- Duplicate W-2 copies for active employees not choosing the on-line self-view and print option will be available in LEO beginning February 1.
- Separated employees needing a duplicate copy of their W-2 should contact their EA/HR Department to complete the Request for Duplicate W-2 Form OSUP/F37. Duplicate W-2 requests for separated employees will not be processed until mid-February.

You must maintain your current contact information in LEO or through your EA/HR Department. This will allow for all notices and updates to be provided to you regarding your paper W-2 and W-2 on-line self-view and print options.

The Division of Administration will continue to inform you, through your agency, of all required information regarding the W-2 on-line self-view and print option, deadlines, and/or contact information changes.

We encourage you to make your election by the December 31 deadline.

If you have any questions regarding this process, please contact Angela Calhoun at 225-342-9677.

INSURANCE & WORKERS COMPENSATION INFORMATION

LOUISIANA WORKERS' COMPENSATION SECOND INJURY BOARD
POST-HIRE/CONDITIONAL JOB OFFER KNOWLEDGE QUESTIONNAIRE

EMPLOYEE: The intent of this questionnaire is to provide your employer with knowledge about any pre-existing medical condition or disability which may entitle your employer to reimbursement from the Louisiana Workers' Compensation Second Injury Board in the event you suffer an on-the-job injury.[1] This reimbursement in no way affects the benefits owed to you by your employer or its insurance company under the Louisiana Workers' Compensation Act. La. R.S. 23:1021-1361. However, your failure to answer truthfully and/or correctly to any of the question on this questionnaire may result in a forfeiture of your workers' compensation benefits.

In order for your employer to be considered for reimbursement from the Second Injury Board, it has to show that it knowingly hired or retained you with a pre-existing medical condition or disability. To establish its knowledge, your employer is requesting that this questionnaire be completed.

INSTRUCTIONS: Please answer ALL questions completely. If a response requires an explanation, please provide a brief description on the Explanation Page. If you have any questions or need help in answering the questions on this form, please ask for assistance from the Employer Representative signing this form.

NOTE: Since this questionnaire contains medical information, you can request that the form be kept CONFIDENTIAL and not made part of your personnel file. Please let your employer know that you want the completed questionnaire placed in a sealed folder for confidentiality purposes.

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS' COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

Employee Signature: _____ Date: _____

Employer Representative Signature: _____ Date: _____

Employer Name: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

[1] Under La. R.S. 23:1371(A), the purpose of the Second Injury Board is to encourage the employment, re-employment, or retention of employees who have a permanent partial disability.

Disease and Other Medical Conditions you currently have or have ever had.

For all conditions that you check yes, write a brief explanation on the Explanation Page.

[Please check the appropriate box next to each. Every illness/injury requires a Yes (Y) or No (N) answer.]

Y N	Y N	Y N	Y N
☐ ☐ Diabetes	☐ ☐ Cerebral Palsy	☐ ☐ Arthritis	☐ ☐ Heart Disease/Heart Attack
☐ ☐ Silicosis	☐ ☐ Tuberculosis	☐ ☐ Parkinson's	☐ ☐ Congestive Heart Failure
☐ ☐ Varicose Veins	☐ ☐ Multiple Sclerosis	☐ ☐ Brain Damage	☐ ☐ Vision Loss, one or both eyes
☐ ☐ Asbestosis	☐ ☐ Post Traumatic Stress	☐ ☐ Asthma	☐ ☐ Disability from Polio
☐ ☐ Hyperinsulinism	☐ ☐ Osteomyelitis	☐ ☐ Dementia	☐ ☐ Psychoneurotic Disability
☐ ☐ Alzheimer's	☐ ☐ Nervous Disorder	☐ ☐ Thrombophlebitis	☐ ☐ Ruptured or Herniated Disc
☐ ☐ Emphysema	☐ ☐ Muscular Dystrophy	☐ ☐ Arteriosclerosis	☐ ☐ Ankylosis or Joint Stiffening
☐ ☐ Hearing Loss	☐ ☐ Migraine Headaches	☐ ☐ Hodgkin's	☐ ☐ High/Low Blood Pressure
☐ ☐ COPD	☐ ☐ Mental Retardation	☐ ☐ Cancer	☐ ☐ Carpal Tunnel Syndrome
☐ ☐ Hypertension	☐ ☐ Kidney Disorder	☐ ☐ Double Vision	☐ ☐ Compressed Air Sequelae
☐ ☐ Head Injury	☐ ☐ Loss of Use of Limb	☐ ☐ Mental Disorders	☐ ☐ Disease of the Lung
☐ ☐ Epilepsy	☐ ☐ Seizure Disorder	☐ ☐ Hemophilia	☐ ☐ Coronary Artery Disease
☐ ☐ Stroke	☐ ☐ Sickle Cell Disease	☐ ☐ Bleeding Disorder	☐ ☐ Heavy Metal Poisoning

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.] For each Yes (Y) answer, please complete the information corresponding to the surgery on the right. Additional information can be provided on the Explanation Page, if necessary.

Y N

☐ ☐ Spinal Disc Surgery — Year (approximate if unsure)_____

☐ ☐ Spinal Fusion Surgery — Year (approximate if unsure)_____

☐ ☐ Amputated Foot — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Leg — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Arm — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Amputated Hand — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Knee Replacement — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Hip Replacement — Left ☐ Right ☐ Year (approx. if unsure) _____

☐ ☐ Other Joint Replacement — Joint _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

☐ ☐ Other Surgical Procedure — Procedure _____ Year _____

Employee Signature:_____ Date: _____

Employer Representative: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) **or** any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

CONDITION: ______________________________ Year Diagnosed (approx): ____________

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: ______________________________

Employee Signature: ______________________________ Date: ____________________

Employer Representative: ______________________________ Date: ____________________

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐
   If "Yes," please list the restrictions: _____
   Were the restrictions: Permanent ☐ Temporary ☐
   Are your activities currently restricted? Yes ☐ No ☐
   What is the medical condition for which you have restrictions? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

   Please list the medical condition being treated: _____

   Doctor's Name: _____ Specialty: _____

   Doctor's Address: _____

3. If you are currently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

   Medication: _____ Prescribing Doctor: _____

   Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐
   If you answered "YES," please provide the date for each injury and the nature of the injury:

   _____

   How long were you on compensation? _____

   Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐
   If you answered YES, please provide:

   Recommended surgery: _____

   Approximate date of recommendation: _____

   Doctor's Name: _____ Specialty: _____

   Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Representative: _____ Date: _____

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF ANY AND ALL WORKERS COMPENSATION BENEFITS UNDER La. R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: _____ Date: _____

Employee Printed Name: _____

TO BE COMPLETED BY EMPLOYER REPRESENTATIVE

EMPLOYER WARNING

PURSUANT TO La. R.S. 23:1208 OF THE LOUISIANA WORKERS' COMPENSATION ACT, IT SHALL BE UNLAWFUL FOR A PERSON, FOR THE PURPOSE OF OBTAINING OR DEFEATING ANY BENEFIT PAYMENT UNDER THE PROVISIONS OF THIS CHAPTER, EITHER FOR HIMSELF OR FOR ANY OTHER PERSON, TO WILLFULLY MAKE A FALSE STATEMENT OR REPRESENTATION. PENALTIES FOR VIOLATIONS INCLUDE IMPRISONMENT, FINES, AND/OR THE FORFEITURE OF BENEFITS.

You must certify the following:

1. That I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire;

2. That I have provided the employee with as many copies of the Explanation Page as needed and have confirmed the number of and labeled the pages of this questionnaire;

3. That I have provided assistance to the employee (if requested) in responding to the questions on this questionnaire;

4. That the information sought by this authorization is made on an applicant for employment only after a conditional job offer has been made and accepted, or on a current employee; and

5. That the information obtained in the authorization will **NOT** be used to discriminate in any manner against the individual who is the subject of this authorization on any basis, in violation of the Americans with Disabilities Act of 1990, 42 U.S.C. §12101, *et seq.*, or any other state or federal law;

6. That if requested, a photocopy of this fully completed and signed form will be provided to the employee.

Employer Representative Signature:_____ Date: _____

Employer Representative Printed Name:_____

Title: _____

BENEFITS INFORMATION

Form 01-13
R112012

DO NOT FAX FORM
PRINT ALL INFORMATION
www.lasersonline.org

LASERS

Louisiana State Employees' Retirement System

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000

ENRLINFO

Benefit Forfeiture
(For Employer Use Only - Do Not Return to LASERS)

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

This form will be completed upon employment of LASERS eligible members hired on or after January 1, 2013. The employing agency will keep the form for their records.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: MEMBER SIGNATURE AND CERTIFICATION

By accepting this position, I understand that I will be enrolled in the Louisiana State Employees' Retirement System.

I further understand that my retirement benefits and the benefits payable to my spouse or children may be forfeited if I am convicted of a public corruption crime of either of the following types:

- Public corruption crime resulting in financial gain or attempted financial gain for myself or a third party.
- Public corruption crime that involves sexual contact with a minor with whom I come in contact by virtue of my public employment.

Signature of Member	Date of Signature

Form 1-01
R122015

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LASERS

Louisiana State Employees' Retirement System

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000
Fax 225.935.2856

ER1

Membership Registration
(For Employer Use Only - Do Not Return to LASERS)

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

A member should read the "Notice of Employees Not Covered by Social Security" disclosing the potential effects of the Government Pension Offset (GPO) and the Windfall Elimination Provision (WEP). A member may repay a refund to LASERS upon returning to state service and contributing to the system for eighteen months according to La. R.S. 11:537(D). **The member must complete Form 1-06, *Designation of Beneficiary*, to name a beneficiary, and submit the form to LASERS.**

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: OPTIONAL MEMBERSHIP (Complete ONLY if age 55 or over and not a LASERS rehired retiree)

☐ At the time of employment I was 60 or older and elect to **(please check option A or B below): (OR)**

☐ At the time of employment I was age 55 or older and have at least 40 quarters in Social Security and I elect to **(please check option A or B below): I will submit a copy of my Social Security Administration's form, SSA-7005-Earnings and Benefits Statement, certifying that I have the required 40 quarters of coverage needed for optional membership.**

A) ☐ Join the Louisiana State Employees' Retirement System (LASERS). I understand that if I join the retirement system I must make employee contributions based on my earnings. I may make application for my employee contributions to be refunded to me, without interest, if I terminate employment for at least 30 days. If I join the retirement system and I am also eligible for a benefit from Social Security, the Social Security benefit may be reduced based on the benefit received from the retirement system.

B) ☐ Join FICA (Medicare included), or join/maintain the Louisiana Deferred Compensation Plan (eligibility and rate depend on employee status), or in some cases, employee may not be required to join either.

SECTION 3: PREVIOUS ENROLLMENT

If you were at any time a member of LASERS or another Louisiana public retirement system, give the name of that system under which the membership was reported:

	From (MM/DD/YY)	To (MM/DD/YY)

My current status with the Louisiana public retirement system listed above is: ☐ Active ☐ Inactive ☐ Refunded ☐ Retired

If your status is RETIRED from a Louisiana public retirement system OTHER than LASERS, please check one:

☐ I elect NOT to join LASERS ☐ I elect to join LASERS: I shall pay employee contributions and expect to work enough years to be entitled to a monthly benefit; otherwise, I will only be eligible to refund my contributions.

Member's Signature	Date

CONTINUE ON NEXT PAGE

Social Security Number

SECTION 4: CURRENT ENROLLMENT - FOR AGENCY INFORMATION ONLY

SERVICE HISTORY

☐ New - first time enrolled in LASERS. Regular members hired on or after July 1, 2015, will have a contribution rate of 8.0 percent in the Regular 4 Plan.

☐ New - first time enrolled in LASERS and enrolled in a Hazardous Duty Plan (HAZ Plan) position on or after January 1, 2011. HAZ Plan members must be enrolled in the HAZ Plan and will contribute at 9.5 percent.

☐ Return to service - previous member of LASERS, whether refunded or not, with a break in service

- ☐ Regular member who is a former member of LASERS prior to July 1, 2006, **DID NOT** refund contributions and will contribute at 7.5 percent in the Regular 1 Plan.
- ☐ Regular member who is a former member of LASERS on or after July 1, 2006, and before January 1, 2011, **DID NOT** refund contributions and will contribute at 8.0 percent in the Regular 2 Plan.
- ☐ Regular member who is a former member of LASERS on or after January 1, 2011, and on or before June 30, 2015, **DID NOT** refund contributions and will contribute at 8.0 percent in the Regular 3 Plan.
- ☐ Regular member who is a former member of LASERS, **DID** refund contributions and will contribute at 8.0 percent in the Regular 4 Plan.

☐ Transfer from another agency - transferring from one reporting agency to another within LASERS without a break in service.

☐ Transfer from another agency on or after January 1, 2011, and enrolled in a HAZ Plan position - transferring from any plan other than the HAZ Plan may elect to remain in that plan or join the HAZ Plan. Form 2-18: *Hazardous Duty Services Plan Election* must be submitted to LASERS. Form 1-11: *Certification of Prior Employment in a Hazardous Duty Position* should be submitted, if applicable.

☐ Transfer from another Louisiana state retirement system on or after July 1, 2015, and **DID NOT** refund - transferring from Teachers Retirement System of Louisiana, Louisiana School Employees' Retirement System, or State Police Pension & Retirement System must submit Form 01-10: *Certification of Membership in a State System Prior to July 1, 2015*, and must be enrolled in the retirement plan in place at the earliest date making the member eligible for membership.

☐ Transfer from another Louisiana state retirement system on or after January 1, 2011, and **DID NOT** refund, and employed in a HAZ Plan position - transferring from Teachers Retirement System of Louisiana, Louisiana School Employees' Retirement System, or State Police Pension & Retirement System may elect to remain in that system if eligible, or may elect to join the HAZ Plan.

☐ Dual employee - currently a member of LASERS under one reporting agency and now enrolling with a second reporting agency. (Usually involves part-time employment, but not necessarily.) Contributions are based on employment with all reporting agencies and are mandatory.

TYPE OF EMPLOYMENT

Types of Employees not Eligible (La. R.S. 11:413):

1. Employees who receive a per diem allowance instead of earned compensation
2. Students, interns, and resident physicians employed for temporary, part time, or periodic work
3. Independent contractors
4. Certain pool positions
5. Certain temporary seasonal employees at the Department of Revenue

Types of Employees not Eligible (La. R.S. 11:413(3)) - except those employees who have ten or more years of creditable service in the system or are returning to work as a re-employed retiree:

1. Job appointments (employment for a fixed period not to exceed two years)
2. Intermittent employees (employment for an indefinite schedule, on an as needed basis)
3. Part-time employees (employees who work 20 hours or less per week)
4. Seasonal employees (employees who work less than five months in a year)
5. Temporary employees (employees performing services under a contractual arrangement for less than two years)

Types of Employees Eligible

1. Full-time - working over 20 hours per week
2. Job Appointment - working two years and one day or longer

CONTINUED ON NEXT PAGE

Social Security Number

EMPLOYEE INFORMATION

Employee Position Title

Hire Date (MM/DD/YY)

☐ Classified ☐ Unclassified

☐ Permanent employee ☐ Temporary employee

☐ Full-time: Full-time status equals _____ hours per day

☐ Part-time: The employee will work _____ hours per week

☐ Job Appointment working 2 years or less

☐ Job Appointment working 2 years and one day or longer

EARNINGS REPORTING: This employee's earnings will be reported as: ☐ 9 months ☐ 10 months ☐ 12 months

SECTION 5: AGENCY CERTIFICATION AND SIGNATURE

I have checked the PA20 and CS02 in ISIS and LASERS Employer Self-Service for previous retirement status. YES ☐ NO ☐

Is this member a LASERS retiree from this or any other state agency? YES ☐ NO ☐

If yes, see Liaison Memos 12-21 and 13-23 to follow the proper rehired retiree enrollment procedures. Failure to properly enroll rehired retirees may result in a cost to the member and agency. If this is a rehired retiree, form 10-2 *Re-employment of Rehired Retiree* must be submitted to LASERS within 45 days of the employment date. If it is not, the member will be rehired under the provisions of re-employed retiree Option 3.

Name of Personnel Officer

Name of Agency

Title

Personnel Officer's Email Address

Daytime Area Code/Phone Number

Signature of Personnel Officer

Date

Agency 3 Digit Number

Form 01-13
R112012

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LASERS

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ENRLINFO

Benefit Forfeiture
(For Employer Use Only - Do Not Return to LASERS)

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

This form will be completed upon employment of LASERS eligible members hired on or after January 1, 2013. The employing agency will keep the form for their records.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: MEMBER SIGNATURE AND CERTIFICATION

By accepting this position, I understand that I will be enrolled in the Louisiana State Employees' Retirement System.

I further understand that my retirement benefits and the benefits payable to my spouse or children may be forfeited if I am convicted of a public corruption crime of either of the following types:

- Public corruption crime resulting in financial gain or attempted financial gain for myself or a third party.
- Public corruption crime that involves sexual contact with a minor with whom I come in contact by virtue of my public employment.

Signature of Member	Date of Signature

Form 01-06
R102018

PRINT ALL INFORMATION
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LASERS

Louisiana State Employees' Retirement System

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000
Fax 225.935.2856

ERBER14

Designation of Beneficiary

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: GENERAL INFORMATION

This designation supersedes all prior designations. You must include ALL beneficiaries that you wish to designate. If percentages are not provided, any amounts payable will be divided equally among all beneficiaries. Primary and contingent beneficiaries must separately total 100%. The number of primary or contingent beneficiaries that you may name is not limited (attach an additional sheet if necessary). "Contingent" beneficiaries are eligible for payment only if all primary beneficiaries die before the member does. If you are not the member, you must submit a Certified copy of a "Power of Attorney" or other legal documents with this form. A COPY OF THE SOCIAL SECURITY CARD AND BIRTH CERTIFICATE FOR EACH BENEFICIARY IS REQUIRED.

SECTION 3: ACTIVE MEMBER BENEFICIARY

Complete this section if you are a non-retired member of LASERS. Named beneficiaries will receive a lump sum of any employee contributions not directed by statute. Do not complete this section if you are completing paperwork to retire and are naming your retirement beneficiaries.

PRIMARY BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number
Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number
Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number
Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

CONTINUE ON NEXT PAGE

Social Security Number

CONTINGENT BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Contingent Beneficiary's Name (optional)	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

SECTION 4: RETIREMENT BENEFIT BENEFICIARY

This section should only be completed if you are submitting a Retirement, Retirement with IBO, DROP, or Disability Retirement application, or if you are updating your current Maximum or Option 1 monthly retirement beneficiary(ies).

PRIMARY BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

CONTINGENT BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Contingent Beneficiary's Name (optional)	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

SECTION 5: DROP OR IBO ACCOUNT BENEFICIARY

This section should only be completed if you are naming or updating your DROP or IBO account beneficiary(ies).

PRIMARY BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

Social Security Number

Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number
Primary Beneficiary's Name	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

CONTINGENT BENEFICIARIES' PERCENTAGES MUST TOTAL 100%

Contingent Beneficiary's Name (optional)	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number
Contingent Beneficiary's Name (optional)	Relation, Trust, Estate	Birth Date	Percentage	☐ Male ☐ Female	Social Security Number

SECTION 6: MEMBER SIGNATURE

I hereby request that my beneficiary(ies) be designated as above. I understand that the beneficiary(ies) designated on this form will receive my contributions to the retirement system, unless I have qualifying survivors (spouse, children) entitled to a monthly survivor's benefit.

Member's Signature	Date

OSUP/F100
07/15

State of Louisiana—Office of State Uniform Payroll
Affordable Care Act (ACA)
Newly Hired Employee Offer of Coverage Worksheet

This worksheet is used to document the LaGov HCM Paid Agency's reasonable expectations regarding the "full-time" status of a newly hired/transferred employee. A copy of this completed form should be maintained in the employee's file.

1. Personnel Area Number/Name	2. Employee Name
3. Personnel Number	4. Date of Hire
5. Expected Length of Employment	

6. Did the newly hired/transferred employee work for any LaGov HCM paid agency in the last 12 months?

- ☐ YES – Proceed to 7
- ☐ NO – Proceed to 9

7. Was the newly hired/transferred employee in a standard or initial measurement period at any agency?

- ☐ YES – Proceed to 9
- ☐ NO – Proceed to 8

If you are unsure, contact the prior employing agency or execute the ACA report (ZP136).

8. Is the newly hired/transferred employee in a current stability or initial stability period at any agency?

- ☐ YES – Employees continues to be eligible for health coverage. Make appropriate entries in LaGov HCM.
- ☐ NO – Proceed to 9

Note: A break in service only ends the stability period if it was: (1) at least a 13 week break in service, OR (2) a break in service of at least four (4) weeks but longer than the prior period of employment.

9. Does the agency expect the newly hired/transferred employee to work at least 30 hours per week at the time of hire/transfer?

- ☐ YES – The offer of health coverage must be made in accordance with OGB guidelines. **Enter applicable information in eEnrollment/LaGov HCM. Document the offer (GB-01) and keep copy for file.**
- ☐ NO – Proceed to 10

*IMPORTANT: The offer of coverage **must** be documented and filed in the employee's file.*

10. Is the newly hired/transferred employee replacing a full-time (at least 30 hours) position? Example: the employee is filling in for a permanent position while the employee holding the position is out on leave.

- ☐ YES – The offer of health coverage must be made in accordance with OGB guidelines. **Enter applicable information in eEnrollment/LaGov HCM. Document the offer (GB-01) and keep copy for file.**
- ☐ NO – Proceed to 11

*IMPORTANT: The offer of coverage **must** be documented and filed in the employee's file.*

11. Is the newly hired/transferred employee a variable hour employee? A variable hour employee is defined as an employee for whom the agency cannot reasonably determine based on the facts and circumstances upon the date of hire whether the new hire will work on average at least 30 hours per week.

OSUP/F100
07/15

State of Louisiana—Office of State Uniform Payroll
Affordable Care Act (ACA)
Newly Hired Employee Offer of Coverage Worksheet

Example: The employee will work 35 hours one week, 27 hours the next week, and 25 hours the following week.

- ☐ YES – The agency will measure the employee over the 24 pay period initial measurement (look-back) period. Enter applicable information in eEnrollment/LaGov HCM. Utilize the ACA report (ZP136) periodically to track hours worked. This report must be run at the end of the IMP to determine if employee meets the ACA definition of full time.
- ☐ NO – Employee is considered a part-time employee (works less than 30 hours per week) and is not eligible for health coverage. Utilize the ACA report (ZP136) periodically to track hours worked. This report must be run at the end of the IMP to determine if employee meets the ACA definition of full time.

Form Completed by (Print Name) Title Date

Definitions

Full-time—The employee is expected to work at least an average of 30 or more hours per week

Part-time—The employee is expected to work less than an average of 30 hours per week.

Variable— It cannot be determined at the date of hire if the employee will work an average of 30 hours per week.

STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM (Page 1 of 2)

Agency Number	Agency Name	Primary Plan Participant/Employee Name	Date of Hire

Section 1 - Primary Plan Participant/ Employee Information

Name *First*	*M.I.*	*Last*	Social Security Number	Date of Birth

Home Phone number	Work/Alt Phone Number	Email Address* (See footnote below)	Gender ☐ Male ☐ Female

Mailing Address (Street or P.O. Box)	City	State	Zip Code	Country

Physical Address (street)	City	State	Zip Code	Country

Section 2 - Rehired Retiree

When a retiree with OGB coverage returns to benefits-eligible employment, the hiring agency must notify OGB within 30 days of reemployment and the hiring agency must begin to pay the employer portion of the Re-employed Retiree premium from the date of hire. Upon resuming retirement status, premiums will revert to the applicable retiree rates (i.e. Retiree without Medicare, Retiree with 1 Medicare, Retiree with 2 Medicare). At that time, the agency from which the retiree originally retired will resume payment of the employer portion of the premium. The employer portion of the premium will be the percentage set at the retiree's initial retirement. For example, an agency paying 19% of a retiree's premium upon retirement will pay 19% of the retiree's premium when the retiree resumes retirement. Retirees who have maintained their OGB health coverage in retirement MAY NOT waive coverage when returning to benefits-eligible employment.

AGENCY RETIRED FROM	RETIREMENT DATE (MM/DD/YYYY)

Section 3 - Enrollment Information

LEVEL OF HEALTH AND LIFE COVERAGE - FOR PLAN SELECTION SEE SECTIONS 4 AND 5

For each dependent, employee must check the box in section 3 if they wish that dependent to have health and/or life coverage. For life insurance, employee must also check the appropriate box of section 5. If adding more than 4 dependents, employee must complete, sign and submit a second GB-01 form.

☐ Employee Only ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Family

NAME (LAST, FIRST, MIDDLE INITIAL)	RELATIONSHIP	SEX	BIRTH DATE (MM/DD/YYYY)	ADD/DE-LETE	SOCIAL SECURITY NUMBER	HEALTH	DEP. LIFE
SPOUSE		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES
DEPENDENT		☐ M ☐ F		☐ ADD ☐ DELETE		☐ YES	☐ YES

Section 4 - Health Plan Selection

COMPLETE THE APPLICABLE SECTION BELOW. SELECT ONLY ONE HEALTH PLAN.

Active Employees and Non-Medicare Retirees

☐ Pelican HRA1000 (Administered by Blue Cross)
☐ Magnolia Local Plus (Administered by Blue Cross)
☐ Pelican HSA775* (Actives Only - Administered by Blue Cross)
$ _____ monthly deduction
☐ Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐ Magnolia Open Access (Administered by Blue Cross)
☐ LSU First Option 1 (for eligible LSU Active Employees/ Non-Medicare Retirees only)

***If you select the Pelican HSA775 plan, you must complete the GB-79 form to open a Health Savings Account in your name with a minimum deposit of $200 provided. Tax implications may apply for certain members.**

Medicare Retirees

OGB Secondary Plans:

☐ Pelican HRA1000 (Administered by Blue Cross)
☐ Magnolia Local Plus (Administered by Blue Cross)
☐ Magnolia Open Access (Administered by Blue Cross)
Optional: Retiree 100
☐ Employee Only ☐ Dependent Only ☐ Employee + 1 Dependent
☐ Magnolia Local (Limited Provider Network - Administered by Blue Cross)
☐ LSU First Option 3 (for eligible LSU Retirees only)

OGB Sponsored Medicare Advantage Plans:

☐ Peoples Health Medicare Advantage Plan
☐ Blue Advantage HMO
☐ Humana Medicare Advantage Employer HMO Plan
Via Benefits (Please call 1-855-663-4228 or visit my.ViaBenefits.com/ogb to enroll.)

MEDICARE VERIFICATION	
☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)	☐ No Coverage ☐ Hospital (Part A) ☐ Medical (Part B) ☐ Drugs (Part D)
A COPY OF MEDICARE CARD MUST BE ATTACHED	

*Note to FSA Enrollees: By providing an email address, you may receive certain benefits-related correspondence through email unless you contact Optum Financial to receive paper notices. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by calling customer service at 1-800-272-8451.

Agency- Continue Completing for on page 2

STATE OF LOUISIANA - OFFICE OF GROUP BENEFITS - ENROLLMENT/CHANGE FORM (Page 2 of 2)

Agency Number	Agency Name	Primary Plan Participant/Employee Name	Social Security Number

Section 5 - Life and Flexible Benefits Plan Selection

LIFE INSURANCE (check one only) OGB FLEXIBLE BENEFITS (check all that apply)

☐ **DECLINE LIFE INSURANCE COVERAGE**

BASIC	BASIC PLUS SUPPLEMENTAL
☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage Eligible Spouse $1,000 Eligible Child $500 ☐ Employee/Dependent Coverage Eligible Spouse $2,000 Eligible Child $1,000	☐ Employee/No Dependent Coverage ☐ Employee/Dependent Coverage Eligible Spouse $2,000 Eligible Child $1,000 ☐ Employee/Dependent Coverage Eligible Spouse $4,000 Eligible Child $2,000

Annual Salary _____ Date of Last Salary Increase _____ Face Life _____

FLEXIBLE BENEFITS (ACTIVE EMPLOYEES ONLY)

☐ Decline flexible spending account
☐ My agency does not participate in OGB's flexible benefits plan
☐ I do want to participate and acknowledge that I have completed the flexible spending arrangement form.

Section 6 - Acknowledge Offer and Decline Health Insurance Coverage (Active Employees Only)

ACKNOWLEDGE OFFER AND DECLINE HEALTH INSURANCE COVERAGE (ACTIVE EMPLOYEES ONLY)

I have been offered health coverage for myself and my eligible dependents. I have voluntarily elected to decline the coverage as indicated below. If I choose to apply for health coverage at a later date, I understand that I may only enroll for health coverage during annual enrollment or as otherwise specified in the OGB plan document in the event I, or my eligible dependents have a Plan Recognized Qualified Life Event.

Reason for Declining Health Coverage Offer:

☐ Other Group Health Coverage (would include being covered as a dependent under an OGB plan)
☐ Other Individual Health Coverage
☐ Medicare, Medicaid, Other, Explain:
☐ I am not enrolled in any health coverage and I do not accept this offer of health coverage
☐ I do not wish to disclose

NOTE TO AGENCY REPRESENTATIVE: If the employee declines health coverage, he or she must acknowledge the offer of coverage by completing the GB-01 form. The acknowledgment must be sent to OGB and a copy retained by the agency participating employer as evidence that the employee was offered health coverage within the time-frames allowed by law and the employee subsequently declined the offer of coverage.

Section 7 - Acknowledgment and Certification

BY SIGNING THIS APPLICATION, I ACKNOWLEDGE AND CERTIFY THE FOLLOWING:

(Please check each box)

☐ I, Primary Plan Participant, acknowledge that I have provided appropriate documents to ogb to verify my eligibility and the eligibility of my covered dependent(s) and those documents are included with this application.

☐ I apply for participation or a change in my participation in the named plan(s) and agree to be bound by the plan's terms and conditions.

☐ I acknowledge and authorize deductions from my earnings or retirement check to pay for insurance for myself and my dependents, if applicable.

☐ I acknowledge and certify that the information provided on this form is true and correct I understand that if I provide false, misleading or incomplete information on this form, it may result in denial or rescission of coverage retroactive to the initial day of coverage.

☐ I accept that this acknowledgment and certification will become a part of my application for coverage and that a copy of my signature is as valid as the original.

☐ I acknowledge that any dis-enrollment from an OGB plan of benefits will result in dis-enrollment from both medical and pharmacy benefits, including, but not limited to, Medicare Part D.

Signature	Date

FOR AGENCY USE

PLAN RECOGNIZED QUALIFIED LIFE EVENT (QLE) FOR APPLICATION (REFERENCE 2023 QLE SPREADSHEET)

QLE code or qualified life event description	Qualified life event date	Add/Drop/Reinstate Coverage
		☐ Add ☐ Drop ☐ Reinstate Coverage

I, Agency Representative, certify that the documentation presented is appropriate and supports the occurrence of the OGB plan-recognized qualified life event referenced above.

Signature of Agency Representative	Date
Printed Name of Agency Representative	Date

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information	Effective Date of Coverage (for office use only) / /		
Last Name First Name MI	Email Address	Phone Number	
Address City State Zip Code			
Your Annual Earnings $ _____	Social Security Number – –	Date of Birth (Month/Day/Year) / /	Date Employed (Month/Day/Year) / /
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Spouse Date of Birth (Month/Day/Year) / /	

Basic Term Life

☐ Coverage amount chosen: $5,000 ☐ No coverage chosen

Basic Plus Supplemental Term Life With Matching Accidental Death & Dismemberment (AD&D)

Enrollment in Employee AD&D coverage is automatic when electing Basic Plus Supplemental Term Life coverage.

☐ Coverage amount chosen: $ ☐ No coverage chosen

Basic Dependent Term Life

You must be enrolled for Basic Term Life to elect Basic Dependent Term Life coverage for your dependents. Spouse coverage cannot exceed 100% of your Basic Term Life coverage amount. Child(ren) coverage cannot exceed 100% of your Basic Term Life coverage amount.

Spouse/Children ☐ No coverage chosen

☐ Coverage amount chosen: $1,000/Children $500

☐ Coverage amount chosen: Spouse $2,000/Children $1,000

Basic Plus Supplemental Dependent Term Life

You must be enrolled for Basic Plus Supplemental Term Life to elect Basic Plus Supplemental Dependent Term Life coverage for your dependents. Spouse coverage cannot exceed 100% of your Basic Plus Supplemental Term Life coverage amount. Child(ren) coverage cannot exceed 100% of your Basic Plus Supplemental Term Life coverage amount.

Spouse/Children ☐ No coverage chosen

☐ Coverage amount chosen: Spouse $2,000/Children $1,000

☐ Coverage amount chosen: Spouse $4,000/Children $2,000

You must also complete a separate beneficiary designation form. If you have any questions, please see Human Resources for details.

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX-_____

Acceptance or Waiver of Coverage

☐ I am enrolling for coverage and I authorize my employer to deduct from my earnings until further notice my contributions for insurance under a contract issued by The Prudential Insurance Company of America. I understand that if I desire to increase the amount of my insurance or add dependent coverage hereafter, I may be required to furnish evidence of insurability for myself and/or my dependents. To the best of my knowledge and belief, I declare the statement above is true and understand it is the basis for determining the contribution for coverage. I also understand that for coverage to become effective, I must be actively at work during the enrollment period and on the effective date of the plan. If I apply for an amount that requires evidence of insurability satisfactory to The Prudential Insurance Company of America, I must be actively at work on the date of approval for the amount requiring satisfactory evidence of insurability.

☐ I do not wish to enroll for any of the above optional coverages. I certify that I have been given the opportunity by my above named employer to enroll for coverage. I understand that if I desire to enroll hereafter, I may be required to furnish satisfactory evidence of insurability to The Prudential Insurance Company of America for myself and/or my dependents.

FLORIDA RESIDENTS – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

NEW YORK RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **This warning ONLY applies to accident and disability coverage.**

I have read and understand the terms and requirements of the fraud warnings included as part of this form.

The policy/certificate provides limited benefits. Review your certificate carefully.

Employee Signature _____ Date Signed (Month/Day/Year) _____

Acceptance of Coverage

FOR INSUREDS WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY – If you wish to enroll your Spouse, and/or eligible child 18 years of age or older for Dependent Life and/or Accidental Death and Dismemberment Insurance coverage, your Spouse, and/or each of your eligible children age 18 years or older must consent to such coverage by signing and dating this consent in the appropriate space(s) below.

Coverage on your Spouse and child(ren) age 18 or older will not become effective unless and until the requisite consent is provided.

Spouse Signature _____ Date Signed (Month/Day/Year) _____

Child Signature _____ Date Signed (Month/Day/Year) _____

Child Signature _____ Date Signed (Month/Day/Year) _____

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information

Last Name	First Name	Middle Initial	Last 4 digits of Social Security No.
			XXX-XX- _____

Important Notices

For residents of all states and jurisdictions except Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, the District of Columbia, Florida, Idaho, Indiana, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia, Washington and West Virginia:
WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he or she is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA RESIDENTS – A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA RESIDENTS - For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA, MASSACHUSETTS, RHODE ISLAND, AND WEST VIRGINIA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA AND TEXAS RESIDENTS - For your protection, California and Texas law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS - It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE RESIDENTS - Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

IDAHO RESIDENTS - Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA RESIDENTS - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE, TENNESSEE, VIRGINIA, WASHINGTON RESIDENTS – It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MARYLAND RESIDENTS – Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA RESIDENTS - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Prudential

ENROLLMENT FORM – State of Louisiana

Agency #

All Eligible Active or Retired Employees Including Members of Boards and Commissions Control # **33624**

Employee General Information			
Last Name	First Name	Middle Initial	Last 4 digits of Social Security No. XXX-XX-_____

Important Notices

NEW HAMPSHIRE RESIDENTS - Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO RESIDENTS - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

OHIO RESIDENTS - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA RESIDENTS - WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

OREGON RESIDENTS - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurance company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

PENNSYLVANIA and UTAH RESIDENTS – Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

Employees and/or Dependents may be ineligible for group insurance coverage while on active duty in the armed forces

Accelerated Death Benefit Option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill or chronically ill. You may wish to seek professional tax advice before exercising this option.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

Basic Term Life, Accidental Death & Dismemberment, Optional Term Life, Dependent Term Life, Long-Term Disability, Short-Term Disability Insurance coverages are issued by The Prudential Insurance Company of America, 751 Broad Street, Newark, NJ 07102. Life Claims: 1-800-524-0542 and Disability Support 1-800-842-1718. The Booklet-Certificate contains all details, including any policy exclusions, limitations, and restrictions, which may apply. If there is a discrepancy between this document and the Booklet-Certificate/ Group Contract issued by Prudential, the terms of the Group Contract will govern. Contract provisions may vary by state. California COA #1179, NAIC#68241. Contract Series: 83500.

Beneficiary Designation - State of Louisiana

Control# 33624

Employee General Information

Last Name	First Name	Middle Initial	Social Security No.
			___ - ___ - ___

Employee / Applicant Beneficiary Designations (to be completed by Employee/applicant or assignee, if assigned)

Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than two primary beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields. Do not name a beneficiary for Dependent Term Life Coverage; these benefits are paid to you while living. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

Basic Term Life, Basic Plus Supplemental Term Life - Primary Beneficiary Designation

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ Trust ☐ Estate ☐ Corporation	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ Trust ☐ Estate ☐ Corporation	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Basic Term Life, Basic Plus Supplemental Term Life - Contingent Beneficiary Designation

- Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than two contingent beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ Trust ☐ Estate ☐ Corporation	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	Zip
Check one, if applicable:	☐ Trust ☐ Estate ☐ Corporation	**Entity Name:**	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	Zip

Employee Signature _____ Date (mm/dd/yyy)_____

If you have any questions, please see Human Resources for details.

Group Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, Newark, NJ 07102. Life Claims: 800-524-0542, Disability Support: 800-842-1718. This brochure is intended to be a summary of your benefits and does not include all plan provisions, exclusions and limitations. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the Group Contract will govern. Contract provisions may vary by state. Contract Series:83500. California COA # 1179 NAIC #68241

Prudential

GL.2005.289 0-48836

State of Louisiana
Office of Group Benefits - Flexible Benefits Plan
Flexible Spending Arrangement Enrollment/Stop Form

2024

*You must complete this form **each year** to participate in a tax-free Flexible Spending Arrangement. Please print.*

***Note to FSA Enrollees:** By providing an email address, you may receive certain benefits-related correspondence through email unless you contact TASC to receive paper notices. You are responsible to provide us with your current email address and to promptly notify us of any changes to your email address by calling customer service at 1-800-422-4661 .*

Social Security Number	Email Address	Payroll System	Agency Number

Last Name (Print)	First Name	Middle Initial

Home Address	City	State	Zip

Home Phone	Daytime Phone	Date of Hire	Number of Pay Periods	Date of Birth	Annual Salary	Payroll Use only	
						Effective Date	First Payroll Date
ENROLLMENT STATUS (CHECK ONE) _____ CHANGE IN STATUS _____ ANNUAL ENROLLMENT _____ NEW HIRE							

Indicate the amount you wish to set aside via tax-free salary deduction by completing the sections below. Complete the worksheets provided in the Flexible Spending Arrangement (FSA) Handbook before deciding on the amount.

- In Box #1, indicate the dollar amount you elect to contribute for the plan year.
- In Box #2, indicate the number of regular payroll checks you expect to receive during the plan year (9, 10, 12, 18, 24).*
- In Box #3, indicate the deduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal Box #1 exactly, the amount in Box #3 may be changed slightly, to reflect rounding. By signing this form, you certify that you expect to receive the number of paychecks listed in Box #2.)
- In Box #4, indicate the annual FSA fee amount (12 months = $24.00). **
- In Box #5, indicate the FSA fee per pay period (paid biweekly is $1.00; paid monthly is $2.00). ***

*If you are a new employee enrolling after the plan year begins, divide by the number of pay periods remaining in the plan year.

Type	*Dollar Amount*	*Number of Regular Payroll Checks**	*Deduction Amount per Paycheck*	*Annual FSA Fee Amount***	*FSA Fee per Pay Period****
General-Purpose Health Care FSA (GPFSA)					
For eligible medical expenses incurred by you, your family members, or both ($600 minimum contribution; $3,200 maximum contribution)					
Limited-Purpose Health Care FSA (LPFSA)					
*For eligible **dental and vision** expenses **only** incurred by you, your family members, or both\. For employees who want to participate in an FSA **and** a Health Savings Account. ($600 minimum contribution; $3,200 maximum contribution)*					
Dependent Care FSA (DCFSA)					
For eligible dependent care expenses of an eligible dependent while you work ($600 minimum contribution) *TAX FILING STATUS - CHECK ONE: _____ Married, filing separately (maximum $2,500) _____ Married, filing jointly (maximum $5,000) _____ Married with incapacitated spouse (maximum $5,000) _____ Single head of household (maximum $5,000) Single (maximum $2,500)*					

IMPORTANT: SALARY REDUCTION AGREEMENT

1. I hereby authorize my employer to reduce my gross salary (before federal and state income taxes are calculated) by the total deduction amount per pay period as indicated above. If applicable, I understand that this salary reduction might produce lower Social Security benefits.
2. I agree to file IRS Form 2441 regarding my Dependent Care FSA.
3. I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year (due to the IRS "use-or-lose" rule).
4. I understand that funds in one FSA cannot be used to reimburse expenses covered by another FSA.
5. I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
6. I understand that funds in any FSA can only be paid out for reimbursement of eligible expenses actually incurred during my period of coverage for the applicable plan year.
7. I understand that improper payments (ineligible expenses) may be withheld from my paycheck or reported as taxable income on my W-2.
8. I understand that the salary deduction amount will include the items specified above and will continue in effect unless I terminate employment or file an approved GB-01 form with the Human Resources office of my employer.
9. I understand and agree that my employer, the Office of Group Benefits and the Flexible Benefits Plan administrator will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year.

Employee Signature	Agency or Payroll System Name		Date Signed
Payroll Officer/Benefits Administrator	Phone Number	OGB Agency Number	Date Signed

STATE OF LOUISIANA DEFERRED COMPENSATION PLAN
9100 Bluebonnet Centre Blvd., Suite 203
BATON ROUGE, LA 70809
Phone: (225) 926-8082
Fax: (225) 296-6832

Hello and welcome to the Deferred Comp Plan!

ONLINE ENROLLMENT

To enroll in the LA Deferred Compensation Plan, simply access the Plan website and follow the prompts.

www.louisianadcp.com

- Select: REGISTER
- Select 1 of 2 choices:
  - "I Do Not Have a PIN" - You may call 800-937-7604 for a Temporary PIN OR you may enter the requested personal data.
  - "I Have a PIN" - You may enter your SSN and PIN number.
- Choose "Continue" once you have advanced into the registration.
- Create a USER ID and password.
- Follow the prompts and choose your contribution amount.
- NOTE: *Your contributions will default into a Target Date Fund (with a 6% contribution rate) based on your date of birth.* Alternatively, you may choose your own investments by clicking on "Customize Enrollment". If you are interested in having your investments managed, you may request a one-on-one phone appointment for assistance in customizing a risk strategy of your retirement goals.

Please let us know if you have any questions or need further assistance.

THE LOUISIANA PUBLIC EMPLOYEES 457(B) DEFERRED COMPENSATION PLAN (PLAN) IS A POWERFUL TOOL TO HELP YOU REACH YOUR RETIREMENT DREAMS. AS A SUPPLEMENT TO OTHER RETIREMENT BENEFITS OR SAVINGS THAT YOU MAY HAVE, THIS VOLUNTARY PLAN ALLOWS YOU TO SAVE AND INVEST EXTRA MONEY FOR RETIREMENT—TAX DEFERRED!

Not only will you defer taxes immediately, but you may also build extra savings consistently and automatically, select from a variety of investment options, and learn more about saving and investing for your financial future.

Read these highlights to learn more about your Plan and how simple it is to enroll. If there are any discrepancies between this document and the Plan Document, the Plan Document will govern.

GETTING STARTED

WHAT IS A 457 DEFERRED COMPENSATION PLAN?

The Plan is a governmental 457 deferred compensation plan, which is a retirement savings plan that allows eligible employees to supplement any existing retirement and pension benefits by saving and investing pretax and/or after-tax Roth dollars through a voluntary salary contribution. Contributions and any earnings on contributions are tax-deferred until money is withdrawn. Distributions are usually taken during retirement, when many participants are typically receiving less income and may be in a lower income tax bracket than while working. Distributions are subject to ordinary income tax.

WHY SHOULD I PARTICIPATE IN THE PLAN?

You may want to participate if you are interested in saving and investing additional money for retirement and/or reducing the amount of current state and federal income tax you pay each year. The Plan can be an excellent tool to help make your future more comfortable.

You may also qualify for a federal income tax credit by participating in this Plan.

For more information about this tax credit, please contact an Empower Retirement representative in your area.[1]

IS THERE ANY REASON WHY I SHOULD NOT PARTICIPATE IN THE PLAN?

Participation may not be advantageous if you are experiencing financial difficulties, have excessive debt or do not have an adequate emergency fund (typically in an easy-to-access account).

WHO IS ELIGIBLE TO ENROLL?

All current full-time and part-time Louisiana public employees are immediately eligible to participate in the Plan.

Certain independent contractors of the State of Louisiana employer may be eligible to participate in the Plan as well. Ask your employer for more information.

HOW DO I ENROLL?

You may enroll through any of the following methods:

1. Complete the appropriate enrollment forms, available through your Retirement Plan Counselor.
2. Complete the appropriate forms, available on the participant website under the *Enroll Now* tab.

3. If you are a LA Gov HCM employee, you may enroll on the participant website with a link under the *Enroll Now* tab.

Indicate the amount you wish to contribute, your investment option selection(s) and your beneficiary designation(s). Please return the form(s) to your Retirement Plan Counselor, fax to the Baton Rouge office at (225) 296-6832 or mail to Louisiana Deferred Comp Plan at 9100 Bluebonnet Centre Blvd. Suite 203, Baton Rouge, LA 70809.

WHAT TYPES OF CONTRIBUTIONS CAN I MAKE?

Traditional 457

» Contributions are made with before-tax dollars.
» Any potential earnings on your contributions grow tax-free, and your distribution is taxable.
» It lowers your current taxable income because you postpone paying taxes on contributions to the Plan.

Roth 457

» Contributions are made with after-tax dollars.
» Any Roth money, including contributions and potential earnings, will grow tax-free in your account.
» Your distribution is income tax-free if you are eligible for a distribution from your Plan, and you withdraw your Roth contributions and any earnings after holding the account for at least five tax years.
» It does not change your current taxable income.

If the Roth option is right for you, make the appropriate changes to your account by completing a Salary Deferral Agreement form. If you are a LA Gov HCM employee, you may make changes via **LouisianaDCP.com** or the voice response system at **(800) 701-8255.**

WHAT ARE THE CONTRIBUTION LIMITS?

In 2017, the maximum contribution amount is 100% of your includible compensation or $18,000, whichever is less. It may be indexed in $500 increments after 2017. If you utilize both the traditional and Roth 457 together, they must not exceed the annual total contribution limit.

Participants in the Plan have two different opportunities to catch up and contribute more during the final years of their career. The "Special Catch-up" allows participants in the three calendar years prior to normal retirement age to contribute more to the Plan (up to double the annual contribution limit—$36,000 in 2017). The additional amount that you may be able to contribute under the Special Catch-up option will depend upon the amounts that you were eligible to contribute in previous years but did not.

Also, participants turning age 50 or older in 2017 may contribute an additional $6,000. You may not use the Special Catch-up provision and the Age 50+ Catch-up provision in the same calendar year. Please contact the Baton Rouge office at **(225) 926-8082** for assistance with Special Catch-up if you think you qualify.

WHAT ARE MY INVESTMENT OPTIONS?

A lineup of core investment options is available through your Plan. Investment option information is available through the website at **LouisianaDCP.com** and the voice response system toll free at **(800) 701-8255.** The website and voice response system are available to you 24 hours a day, seven days a week.

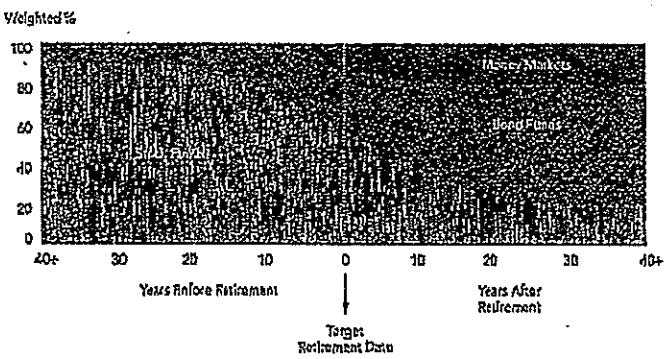
If you enroll for the first time but don't choose any investment options, you will be defaulted into a BlackRock LifePath Fund[2] based on your date of birth (*see the chart below*). Target date funds are a diversified mix of underlying funds whose asset allocations change over time to become more conservative as you near retirement.

Default Fund Name[2]	Birth Year
BlackRock LifePath Index Retirement Fund J	1949 or before
BlackRock LifePath Index 2015 Fund J	1950-1954
BlackRock LifePath Index 2020 Fund J	1955-1959
BlackRock LifePath Index 2025 Fund J	1960-1964
BlackRock LifePath Index 2030 Fund J	1965-1969
BlackRock LifePath Index 2035 Fund J	1970-1974
BlackRock LifePath Index 2040 Fund J	1975-1979
BlackRock LifePath Index 2045 Fund J	1980-1984
BlackRock LifePath Index 2050 Fund J	1985-1989
BlackRock LifePath Index 2055 Fund J	1990-1994
BlackRock LifePath Index 2060 Fund J	1995 or later

The investments in the target date funds will gradually shift from more aggressive to more conservative as the target date approaches. The funds are designed to provide an age-appropriate mix of long-term appreciation and capital preservation and are adjusted based on the number of years left until the funds' target date.

The funds provide a professionally allocated mix from your first days in the Plan all the way through retirement.

This slow transition of the funds' asset allocation from more aggressive investments to more conservative investments is often referred to as the fund's "glide path." The date in a target date fund represents an approximate date when an investor would expect to retire. The principal value of the funds is not guaranteed at any time, including at the target date.



FOR ILLUSTRATIVE PURPOSES ONLY. Intended to illustrate possible investment portfolio allocations that represent an investment strategy based on risk and return. This is not intended as financial planning or investment advice.

Please consider the investment objectives, risks, fees and expenses carefully before investing. For this and other important information, you may obtain prospectuses for mutual funds, any applicable annuity contract and the annuity's underlying funds, and/or disclosure documents from your registered representative. For prospectuses related to investments in your Self-Directed Brokerage Account (SDBA), contact TD Ameritrade at (866) 766-4015. Read prospectuses carefully before investing.

SELF-DIRECTED BROKERAGE

In addition to the core investment options, a self-directed brokerage account (SDBA) is available through TD Ameritrade. The SDBA allows you to select from numerous mutual funds for an additional annual administrative fee of $60 per person, deducted from your account at $15 quarterly (plus any additional trading and transaction fees).

You are required to maintain a minimum balance in your core account of $2,500.

The SDBA is intended for knowledgeable investors who acknowledge and understand the risks associated with the investments contained in the SDBA.

SDBA accounts are not monitored by the Commission or investment consultant to the Plan. You will receive a separate statement of your holdings and activity from TD Ameritrade.

Review the SDBA Frequently Asked Questions (FAQs) on the participant website, **LouisianaDCP.com**, for more information.

Go to the *Investment Information* tab, then click the *Self-Directed Brokerage* link.

MANAGING YOUR ACCOUNT

HOW DO I KEEP TRACK OF MY ACCOUNT?

Empower Retirement will mail a quarterly account statement to you, showing your account balance and activity. You can also check your account balance and move money among investment options via the website at **LouisianaDCP.com** or the voice response system at **(800) 701-8255.**

You will also receive a separate quarterly statement from TD Ameritrade that will detail the investment holdings and activity within your SDBA, including any fees and charges imposed in connection with the SDBA.

HOW DO I MAKE INVESTMENT OPTION CHANGES?

Use your username and passcode to access the website, or you can use your Social Security number and passcode to access the voice response system.[3] You can move all or a portion of your existing balances among investment options (subject to Plan rules) and change how your payroll contributions are invested.[2]

HOW DO I MAKE CONTRIBUTION CHANGES?

Download the Salary Deferral Agreement form from **LouisianaDCP.com** or call the local Empower Retirement office in Baton Rouge. A friendly and helpful representative will assist you in getting the current form. If you are a LA Gov HCM employee, you may log into your account and make the contribution changes.

ROLLOVERS

MAY I ROLL OVER MY ACCOUNT FROM MY FORMER EMPLOYER'S PLAN?

Yes. However, only approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an Individual Retirement Account (IRA) may be rolled over to the Plan.*

MAY I ROLL OVER MY ACCOUNT IF I LEAVE EMPLOYMENT WITH MY CURRENT EMPLOYER?*

If you sever employment with your current employer, you may roll over your account balance to another eligible governmental 457(b), 401(k), 403(b) or 401(a) plan if your new employer's plan accepts such rollovers. You may also roll over your account balance to an IRA. No taxes will be withheld from your transfer amount.

Please keep in mind that if you roll over your Plan balance to a 401(k), 403(b) or 401(a) plan or IRA, distributions taken before age 59½ may also be subject to the 10% early withdrawal federal tax penalty. Please contact your Empower Retirement representative for more information.[1]

VESTING

WHEN AM I VESTED IN THE PLAN?

Vesting refers to the percentage of your account you are entitled to receive from the Plan upon the occurrence of a distributable event. Your contributions to the Plan and any earnings they generate are always 100% vested (including rollovers from previous employers).

DISTRIBUTIONS

WHEN CAN I RECEIVE A DISTRIBUTION FROM MY ACCOUNT?

There is no 10% early withdrawal penalty for a qualifying distribution event. Qualifying distribution events are as follows:

- Retirement
- Unforeseeable emergency
- Severance of employment (as defined by the Internal Revenue Code provisions)
- Attainment of age 70½
- Death (your beneficiary receives your benefits)
- In-service transfer to purchase service credit
- In-service de minimis

Each distribution is subject to ordinary income tax except for an in-service transfer to purchase service credit.

* You are encouraged to discuss rolling money from one account to another with your financial advisor/planner, considering any potential fees and/or limitation of investment options.

NO EARLY WITHDRAWAL PENALTIES

Early distribution penalties do not apply to 457 deferred compensation plans for eligible withdrawals of 457 money. Any withdrawals will be taxed as ordinary income and will be subject to a 20% mandatory withholding. Louisiana state income tax will also be withheld.

WHAT ARE MY DISTRIBUTION OPTIONS?

1. Leave the value of your account in the Plan until a future date.

2. You may be able to receive payment in the following form:
   - » Periodic payments
   - » Fixed annuity payments
   - » Partial lump sum
   - » A lump sum

3. Roll over your account balance to an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or to an IRA.*

WHAT HAPPENS TO MY ACCOUNT WHEN I DIE?

Your designated beneficiary(ies) will receive the remaining value of your account, if any. Your beneficiary(ies) must contact the Plan administrator to request a distribution.

FEES

ARE THERE ANY RECORDKEEPING OR ADMINISTRATIVE FEES TO PARTICIPATE IN THE PLAN?

The Plan will assess an administrative fee, based on the following schedule, which will be assessed quarterly and will be disclosed on the *Transaction Detail* section of your quarterly statement under the *Withdrawals/Expenses* heading.

The annual fee is 0.18% of the first $50,000 in your account, with a minimum fee of $10 per year and a maximum of $90. Every quarter, all participants will be assessed $2.50 up to a balance of $5,555.56, with 0.045% charged on balances from $5,555.57 up to $50,000.

The minimum quarterly fee is $2.50; the maximum quarterly fee is $22.50. If your balance exceeds $50,000, you are charged the maximum fee of $90 per year, or $22.50 per quarter, but you will pay nothing on the balance of $50,000.01 and above.

EXAMPLES

For a $10,000 balance:

- » You'll be charged $2.50 *every quarter* on the balances up to $5,555.56. The remaining $4,444.44 will be charged a fee of 0.045%, or $2 ($4,444.44 x 0.00045 = $2).
- » The total charged on the $10,000 balance will be $4.50 per quarter.

For a $100,000 balance:

- » You'll be charged $2.50 *every quarter* on the balances up to $5,555.56. Additionally, $44,444.44 will be charged a fee of 0.045%, or $20 ($44,444.44 x 0.00045 = $20). There is no fee for the portion of the balance above $50,000.
- » The total charged on the $100,000 balance will be $22.50 per quarter.

ARE THERE ANY FEES FOR THE INVESTMENT OPTIONS?

All loads (sales charges) on purchase transactions are waived on core investment options within the Plan.

Each investment option has an expense ratio that varies by investment option. These fees are deducted by each investment option's management company before the daily price or performance is calculated. Fees pay for investment management expenses, fund operating expenses, and revenue sharing.

These expense ratios are listed under the *Investment Information* tab then *Investment Performance* link at **LouisianaDCP.com**. For example, a $5,000 balance in a fund with a 0.96% expense ratio would be assessed a fee of $12 per quarter. This implicit fee is built into or included in the share price of the investment option.

Funds may impose redemption fees on certain transfers, redemptions or exchanges. Asset allocation funds may be subject to a fund operating expense at the fund level, as well as prorated fund operating expenses of each underlying fund in which they invest. For more information on all applicable fees, please refer to the fund prospectus. Prospectuses are available under the investment information tab at **LouisianaDCP.com.**

ARE THERE ANY DISTRIBUTION FEES?

There are currently no distribution fees for the Plan.

LOANS

MAY I TAKE A LOAN FROM MY ACCOUNT?

Your Plan allows you to borrow the lesser of $50,000 or 50% of your total account balance. The minimum loan amount is $1,000, and you have up to five years to repay your loan—up to 15 years if the money is used to purchase your primary residence.

Participants may have a maximum of one outstanding loan at any time. There is a $50 origination fee for each loan, plus an ongoing quarterly maintenance fee of $6.25. The loan origination fee is deducted from the principal balance of the loan proceeds. All loan payments are payroll deducted. If your employer opts out of this process, you will not be eligible for a loan.

The quarterly maintenance fee is assessed against your remaining account balance. The interest rate for the loan is 2% over the Prime Rate as published in *The Wall Street Journal* on the first business day of the month before the loan is originated. For more information on loans, contact the Louisiana Deferred Compensation Plan office at **(225) 926-8082** or **(800) 937-7604.**

Important note: In the event you pay off a loan, there is a 30-day waiting period before another loan request can be processed.

TAXES

HOW DOES MY PARTICIPATION IN THE PLAN AFFECT MY TAXES?

Because traditional 457 contributions are taken out of your paycheck before taxes are calculated, you pay less in current income tax.

You do not report any current earnings or losses on your account on your current income tax return either. Your account is tax-deferred until you withdraw money, which is usually during retirement.

Distributions from the Plan are taxable as ordinary income during the years in which they are distributed or made available to you or your beneficiary(ies).[1]

INVESTMENT ASSISTANCE

CAN I GET HELP WITH MY INVESTMENT DECISIONS?

Employees of the State of Louisiana and Empower cannot give investment advice. There are financial calculators and tools on the website that can help you determine which investment options might be best for you if you would like to construct your Plan account yourself.

HOW CAN I GET HELP CHOOSING MY INVESTMENT OPTIONS?

Your Plan offers a suite of services called Empower Retirement Advisory Services (Advisory Services), offered by Advised Assets Group, LLC (AAG), a registered investment adviser. As a participant, you may select the Managed Account service, which has AAG, a registered investment adviser, manage your Plan account for you. If you prefer to manage your retirement account on your own, you may select any investment option or options, and you may use the Online Investment Guidance and/or Online Investment Advice tools. These services provide a personalized retirement strategy for you based on your investment goals, time horizon and risk tolerance.

HOW DO I GET MORE INFORMATION?

Visit the website at **LouisianaDCP.com** or call the voice response system toll free at **(800) 701-8255** for more information.

The website provides information regarding your Plan, financial education information, financial calculators and other tools to help you manage your account.

We recommend setting an appointment with an Empower Retirement representative by contacting the Louisiana Public Employees Deferred Compensation Plan office at:

9100 Bluebonnet Centre Blvd., Suite 203
Baton Rouge, LA 70809
(225) 926-8082

For more detailed information, please visit your Plan's website at **LouisianaDCP.com** or call the voice response system toll free at **(800) 701-8255** to speak with an AAG investment adviser representative.

There is no guarantee that participation in any of the advisory services will result in a profit or that the account will outperform a self-managed portfolio invested without assistance.

WHAT FEES DO I PAY TO PARTICIPATE IN ADVISORY SERVICES?

Three levels of service are available with Advisory Services:

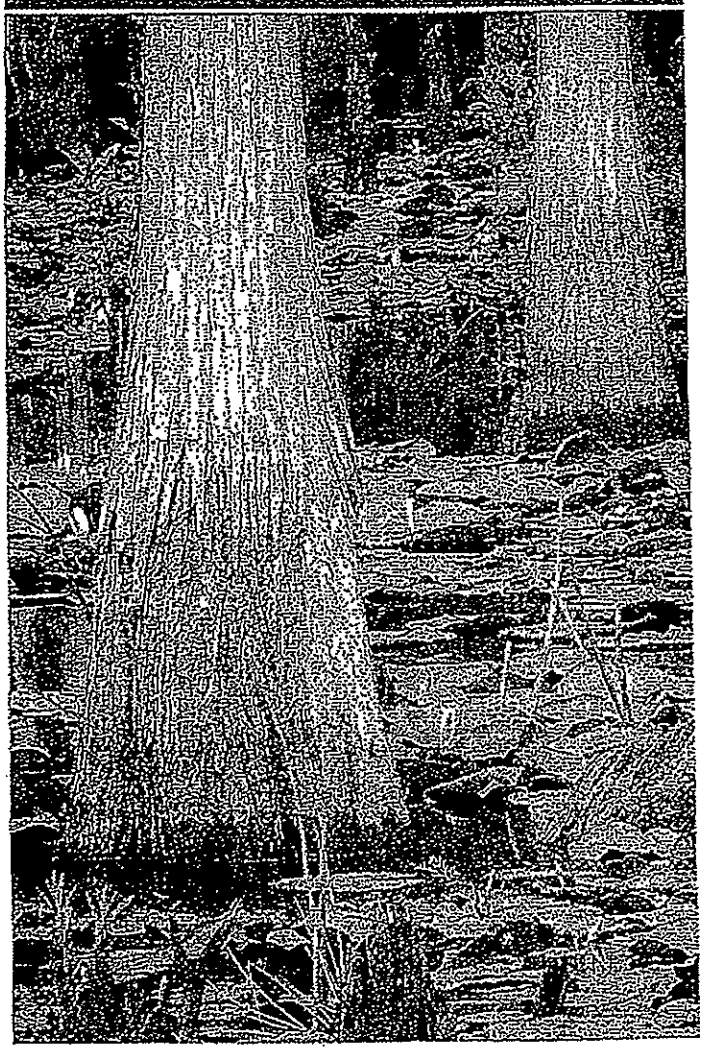
- » Online Investment Guidance: No additional fee.
- » Online Investment Advice: A $25 annual fee assessed to your account at $6.25 quarterly.
- » Managed Account service: If you choose to have AAG manage your account for you, the annual Managed Account service fee will automatically be deducted from your account balance quarterly based on a percentage of your account balance, as the table below shows.

PARTICIPANT ACCOUNT BALANCE	ANNUAL MANAGED ACCOUNT FEE
Less than $100,000	0.45%
Next $150,000	0.35%
Next $150,000	0.25%
Greater than $400,000	0.15%

For example, if your account balance is $50,000, the maximum annual fee will be 0.45%, or 0.1125% per quarter, which equates to $225 annually, or $56.25 quarterly.

As shown in the table below, if your account balance is $125,000, the first $100,000 will be subject to a maximum fee of 0.45% annually, or 0.1125% quarterly, and the next $25,000 will be subject to a maximum annual fee of 0.35%, or 0.0875% quarterly.

$100,000 x 0.1125%	= $112.50 quarterly
$25,000 x 0.0875%	= $21.88 quarterly
Total quarterly fee	= $134.38 (or $537.52 yearly)



1 Representatives of Empower Retirement do not offer or provide investment, fiduciary, financial, legal or tax advice or act in a fiduciary capacity for any client unless explicitly described in writing. Please consult with your investment advisor, attorney and/or tax advisor as needed.

2 Asset allocation and balanced investment options and models are subject to the risks of the underlying funds, which can be a mix of stocks/stock funds and bonds/bond funds. For more information, see the prospectus and/or disclosure documents.

3 The account owner is responsible for keeping their PIN/passcode confidential. Please contact Client Services immediately if you suspect any unauthorized use.

Core securities, when offered, are offered through GWFS Equities, Inc. and/or other broker-dealers.

GWFS Equities, Inc., Member FINRA/SIPC, is a wholly owned subsidiary of Great-West Life & Annuity Insurance Company.

Brokerage services provided by TD Ameritrade Inc., member FINRA/SIPC/NFA. TD Ameritrade is a trademark jointly owned by TD Ameritrade IP Company, Inc. and The Toronto-Dominion Bank. All rights reserved. Used with permission. Additional information can be obtained by calling TD Ameritrade at (866) 766-4015. TD Ameritrade and GWFS Equities, Inc. are separate and unaffiliated.

Empower Retirement Advisory Services are offered by Advised Assets Group, LLC, a registered investment adviser and wholly owned subsidiary of Great-West Life & Annuity Insurance Company.

INFORMATION TECHNOLOGY FORMS

IT

Overview

The State of Louisiana is entrusted with sensitive, proprietary and confidential information, including Protected Health Information (PHI), Federal Tax Information (FTI), Criminal Justice Information (CJI), and Personally Identifiable Information (PII) and acknowledges that it should take steps to protect that information. One such step is to confirm that users of the State's information take responsibility for the protection and appropriate use of the State's information in accordance with the State's Information Security policies and procedures. Effective protection of such information requires the participation and support of every State employee, independent contractor and third party affiliate ("Users"). It is the responsibility of every User to acknowledge and follow the guidelines in this Policy.

Purpose

The purpose of this Policy is to provide guidance for the acceptable use of computer equipment and information within an Agency. Inappropriate use exposes the State to risks such as data loss, data corruption, unplanned service outage, unauthorized access to Agency data, and potential legal issues.

Applicability

This policy applies to all Users, including State employees, independent contractors and all other workers at an Agency, including all personnel affiliated with third parties. This policy applies to all computing systems, electronic media and printed materials that are utilized, owned, managed, or leased by an Agency or the Office of Technology Services (OTS).

General Requirements

All Users are responsible for exercising good judgment regarding use of State resources in accordance with State's Information Security policies and procedures. The State's resources may not be used for any unlawful purpose. If you have a question regarding the proper use of technical resources, contact the Information Security Hotline toll free at (844) 692-8019.

All State systems, including handheld or mobile devices, computing devices, operating systems, applications, storage media, network accounts, Internet, Intranet, Extranet, and remote access are the property of State. These systems are to be used for business purposes in serving the interests of State, and of Agency clients and customers in the course of normal operations.

Any personal device used in serving the interests of State, must be approved by applicable Agency leadership and the Information Security Team (IST).

Any data created or stored on Agency computing systems remains the property of the Agency. Any personal use of the Agency systems, including any documents or emails, are also the property of the Agency and the State makes no guarantee as to the confidentiality of personal use of Agency systems.

For security, compliance, and maintenance purposes, authorized personnel may monitor and audit Agency computing systems and networks per the State's policies and procedures and to confirm compliance.

User Accounts

The State's Users are responsible for the security of data, accounts, and systems under their control.

Keep passwords secure and do not share account or password information with anyone. For example, do not write passwords down, do not email them and always use complex passwords (e.g., at least 8 characters long using a combination of lower case, upper case, numbers, and special characters).

Providing access to another individual, either deliberately or through failure to secure its access, is a violation of this Policy.

If you believe that you have been granted access to systems or data outside the scope of your employment responsibilities or job function, please contact the Information Security Hotline toll free at (844) 692-8019.

Computing Systems

Users are responsible for ensuring the protection of assigned computing devices, including any electronic devices such as laptops, PDAs, mobile devices, and electronic media.

Users are also responsible for ensuring the protection of any personal devices used in the interest of the State.

State Employees using their vehicles to transport the State's Computing Systems should exercise the utmost caution to safeguard the privacy of and access to such devices. At no time should such equipment be left on car seats, in plain view, in unlocked vehicles or stored in vehicles overnight.

Computing Systems that are stored overnight at non State facilities must be secured with reasonable assurance of privacy to the Data residing on the Systems.

Users of Agency Computing Systems must promptly report any theft or loss to the End User Support Services.

Security and Access Requirements

All State Computer Systems or Agency approved personal devices used for State business purposes (e.g., PCs, laptops, workstations, smartphones, etc.) should be secured with a password-protected screensaver with the automatic activation feature set at 15 minutes or less.

Users shall not create new passwords that are similar to passwords that have been previously used; create passwords that contain any reference to the State in any form (i.e., Pelican, Saints, etc.); create passwords that contain any personal data such as any portion of the user ID or name, a spouse's name, or a pet's name; or create passwords that appear in the dictionary.

Users should secure their workstations by logging off or locking (control-alt-delete or Windows Key + L) the device when unattended.

Users must use due care when transmitting or storing sensitive information. Communications outside of an Agency Network should use mechanisms approved by the Information Security Team (IST) for protecting Confidential or Restricted Data (e.g., encryption).

Portable computers are especially vulnerable and will be protected by a current Antivirus solution and Personal Firewalls, installed or approved by OTS, and may not be disabled or modified by Users.

Users must use extreme caution when accessing electronic media received from outside the State.

Users shall take the necessary and appropriate precautions when opening attachments or emails and shall not open or click on attachments or emails when unsure of the legitimacy of the source or sender.

Known incidents or infections from a virus, malware, or other malicious software should be immediately reported to the Information Security Team.

Streaming media should only be accessed for business purposes from trusted commercial sites. All other streaming media is prohibited.

Meeting hosts should verify that all meeting attendees are authorized access to information shared during meetings (including online meetings). Remote meetings security features, such as pass codes or passwords, should be used to restrict access to the meeting to only authorized individuals. Remote meeting presenters should take care to close, or protect, Confidential or Restricted Data while in "desktop sharing" mode.

Users will take reasonable steps to protect all State property and information from theft, damage, or misuse. This includes maintaining and protecting User workspace, equipment, and information from unauthorized access whether working at Agency facilities or offsite.

Users must use only authorized Instant Messenger clients; all other forms of instant messenger software are prohibited.

Newsrooms, Social Media Sites, and Social Networking Sites

Postings by State Employees regarding Agency business information or news to newsgroups, chatrooms, Internet Relay Chat (IRC), Facebook, Myspace, or other social networking or social media sites is strictly prohibited unless expressly approved in writing by the Agency Communication Director or Executive Leadership. If the User identifies himself or herself as employee or agent of the Agency on any Internet site, any postings to such sites must contain a clear disclaimer that the opinions expressed are solely those of the author and do not represent the views of the Agency or the State of Louisiana.

Virtual Private Network (VPN) Usage

It is the responsibility of users with VPN privileges to protect their VPN login and account information.

Connections to State resources via the VPN must originate from Agency authorized End User devices.

Users understand and acknowledge that by using VPN technology the connected computing resource is a de facto extension of the State's network, and as such is subject to the same rules and regulations that apply as if connected locally to the network.

Connections to non-State VPNs from within a State network must be specifically authorized by the Information Security Team (IST).

Physical Security

A State issued identification badge must be worn on your person in a visible location at all times within a State facility. The identification badge must be properly secured and a lost badge must be immediately reported to the Information Security Team (IST).

Do not facilitate the entry of non-badge personnel at any time. All visitors must check in at the reception area, clearly wear the Visitor badge at all times, and remain with their designated escort at all times. Guests are not allowed in the State facilities after hours except with the specific authorization of Agency leadership.

Individuals with Agency provided equipment must take appropriate measures to protect the equipment from theft, unauthorized use, or other activity that violates the State's Information Security Policy.

Individuals with access to Confidential or Restricted Data should maintain a clean desk, pickup printed materials in a timely manner and appropriately secure paper based documents when they are not in use.

Privileged User Accounts

Users with privileged user accounts (*e.g.*, administrator or super-user accounts) must agree to the following:

- Individuals with Privileged User Accounts understand it is their responsibility to comply with all security measures necessary and assist in enforcing the Information Security Policy.
- Privileged User Accounts may only be used for valid business functions that require privileged access. Privileged account users must still abide by the least privilege principal and must not access or alter data for which they have no valid business reason to do so.
- Individuals will login to an Agency environment using standard user credentials and then log in to a specific privileged account, except when logging directly into a system interface console.
- Privileged user accounts may not be used to modify the individual's standard user account.
- Privileged user accounts must comply with requirements of the Information Security Policy prior to modifying any system or user account.
- Individuals with privileged user accounts understand and acknowledge that all privileged user account activity is closely monitored. Individuals with privileged user accounts may not use those accounts to modify, alter, or destroy monitoring log data, except as required by their position responsibility as it relates to log rotation.

- Individuals with privileged user accounts, and their supervisor or manager, will notify the Information Security Team when the privileged user account is no longer required to perform that individual's job function.

Unacceptable Use

The following activities are, in general, prohibited. To the extent a State User needs to be exempted from one of the following restrictions for legitimate job responsibilities (e.g., systems administration staff may have a need to disable the network access of a host if that host is disrupting production services), that State User will be provided express authorization from the Information Security Team. The activities below are by no means exhaustive, but attempt to provide a framework for activities which fall into the category of unacceptable use.

System and Network Activities

The following activities are strictly prohibited, with no exceptions:

- Engaging in any activity that is illegal under local, federal, or international law.
- Violations of the rights of any person or company protected by copyright, trade secret, patent or other intellectual property, or similar laws or regulations, including the installation or distribution of "pirated" or other software products that are not appropriately licensed for use by the State of Louisiana.
- Unauthorized copying of copyrighted material including digitization and distribution of photographs from magazines, books or other copyrighted sources, copyrighted music, and the installation of any copyrighted software for which the State or the end user does not have an active license is strictly prohibited. The use of any recording device, including digital cameras, video cameras, and cell phone cameras, within the premises of any State properties to copy or record any Internal, Confidential, or Restricted Data is prohibited.
- Connecting network devices such as wireless access points or personal laptops into the State's network environment without proper authorization from the Information Security Team (IST).
- Intentional introduction of malicious programs into the network or server (e.g., viruses, worms, Trojan horses, e-mail bombs, etc.).
- Revealing your account password to others or allowing use of your account by others. This includes family and other household members when work is being done at home.
- Using an Agency computing asset to actively engage in procuring or transmitting material that is in violation of sexual harassment or hostile workplace laws in the user's local jurisdiction.
- Making fraudulent offers of products, items, or services originating from any State issued user account.
- Effecting security breaches or disruptions of network communication. Security breaches include accessing data of which the individual is not an intended recipient or logging into a server or account that the individual is not expressly authorized to access, unless these duties are within the scope of regular duties. For purposes of this section, "disruption" includes degrading the performance, depriving authorized access, disabling or degrading security configurations.
- Port scanning or security scanning is expressly prohibited unless prior approval is granted by the Information Security Team.
- Executing any form of network monitoring which will intercept data not intended for the user's host, unless this activity is a part of the user's normal job/duty.
- Circumventing user authentication or security of any host, network or account.
- Interfering with or denying service to any User (e.g., denial of service attack).
- Intentionally restrict, disrupt, impair, or inhibit any network node, service, transmission, or accessibility.
- Utilizing unauthorized peer-to-peer networking or peer-to-peer file sharing.
- Utilizing unauthorized software, hardware, proxy avoidance websites or services, or any other means to access to any internet resource or website that has been intentionally blocked or filtered by the State, Agency, or IST.

Email and Communications Activities

- Sending non-business related unsolicited email messages, text messages, instant messages, or voice mail, including the sending of "junk mail" or other advertising material to individuals who did not specifically request such material (email spam).
- Engaging in any form of harassment or discrimination through email or other electronic means.
- Use of personal email account from the State networks.
- Forging, misrepresenting, obscuring, suppressing, or replacing a user identity on any electronic communication to mislead the recipient about the sender.
- Soliciting email for any other email address (e.g., phishing), other than that of the poster's account, with the intent to harass or to collect replies.
- Creating or forwarding chain letters, Ponzi or other pyramid schemes to a State User, unless specifically requested by such State User.
- Posting non-business-related messages to a large numbers of Usenet newsgroups (newsgroup spam).
- E-mail may not be stored on personal devices (e.g., home computers, personal laptops, PDA's, Smartphones, etc.) except as authorized by the Information Security Team (IST).
- Text messages should not to be used for business discussions. Confidential and Restricted Data shall not be communicated over text messaging.

Users of Confidential and Restricted Information

- By signing this Agreement, Users acknowledge that they are aware of and understand the State's policies regarding the privacy and security of individually identifiable health, financial, criminal and other personal information of individuals and employees, including the policies and procedures relating to the use, collection, disclosure, storage, and destruction of Confidential and Restricted Data.
- In consideration of Users' employment or association with the State and as an integral part of the terms and conditions of such employment or association, Users covenant, warrant, and agree that they shall not at any time, during their employment, contract, association, or appointment with the State or after the cessation of such employment, contract, association, or appointment, access or use Confidential or Restricted Data except as may be required in the course and scope of their duties and responsibilities and in accordance with applicable law and corporate and departmental policies governing the proper use and release of Confidential or Restricted Data.
- Users must understand and acknowledge their obligations outlined hereinabove will continue even after the termination of employment, contract, association, or appointment with the State.
- Users must also understand that the unauthorized use or disclosure of Restricted Data shall result in disciplinary action up to and including termination of employment, contract, association, or appointment, the institution of legal action pursuant to applicable state or federal laws, and reports to professional regulatory bodies.
- Users further acknowledge that by virtue of their employment, contract, association, or appointment with the State, they may be afforded access to Confidential Information concerning the operations and practices of a State Agency, which shall specifically include, but shall not be limited to inventions and improvements, ideas, plans, processes, financial information, techniques, technology, trade secrets, manuals, or other information developed, in the possession of, or acquired by or on behalf of the State, which relates to or affects any aspect of Sate's operations and affairs ("Confidential Information"). Users agree that they will not use, disclose, or distribute Confidential Information or information derived therefrom except for the exclusive benefit of the State Agency.
- Users understand, acknowledge, and agree that nothing contained herein shall be deemed or regarded as an employment contract or any other guarantee of employment, and shall not otherwise alter or affect User status as an at-will employee (or where applicable, independent contractor) of the State.

Enforcement

Any User found to have violated this Policy may be subject to disciplinary action, up to and including dismissal, or criminal or civil legal actions.

	State Employee	Contractor
Name:		
Title:		
Agency:		
Phone:		
Email:		
Signature:		
Date:		

Office of the State Americans with Disabilities Act Coordinator (OSADAC)

VOLUNTARY SELF-IDENTIFICATION OF DISABILITY FORM

Employee Name: _____ Personnel #: _____

Why are you being asked to complete this form?

As an executive branch state agency, the [Office of Elderly Affairs is required by La. R.S. 46:2597 to establish annual strategies and goals related to employment of individuals with disabilities. In order to effectively measure and report our progress to this end, La. R.S. 46:2597 requires us to ask employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five (5) years.

Identifying yourself as an individual with a disability is **voluntary**, and we hope that you will choose to do so (if applicable). Your answer will be maintained confidentially and will not be seen by hiring officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way. For more information about this form or the Americans with Disabilities Act, visit the Office of the State Americans with Disabilities Act (ADA) Coordinator's website at https://www.doa.la.gov/office-of-state-ada-coordinator/.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment that substantially limits a major life activity, or if you have a history or record of such an impairment. Disabilities include, but are not limited, to:

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition, for example, migraine headaches, Parkinson's disease or Multiple Sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, Post Traumatic Stress Disorder (PTSD) or major depression

Please check ONE of the boxes below:

☐ **YES**, I have a disability ☐ **NO**, I do not have a disability ☐ I do not wish to answer

You are encouraged to carefully review our agency's policy specific to the Americans with Disabilities Act and/or Disability Rights, and to request workplace accommodations as may be needed for your disability.

Employee Signature: _____

Date: _____

In accordance with La. R.S. 46:2597, this form shall be confidential and filed in a folder separate from the employee's personnel file.

GOEA TELEWORK AGREEMENT FORM

This document is intended to ensure that both the supervisor and the employee have a clear, shared understanding of the employee's telework arrangement. Each telework arrangement is unique depending on the needs of the agency, position, supervisor, and employee.

This Agreement in no way alters my current employment relationship or my obligation to observe all applicable agency rules, policies, and procedures. All existing terms and conditions of employment, including but not limited to my position description, salary, benefits, leave, overtime, etc. remain the same as if I worked at the primary worksite.

Employee Telework Information

Employee Name:		Personnel #:	
Job Title:			
Office/Division:			
Supervisor:			
Alternative Worksite Address:	*Enter Street Address* *Enter City, State* *Enter Zip Code* *Enter Parish*		
Type of Telework:	☐ Telework-Formal ☐ Telework-Situational *Per the GOEA's Telework Policy all situational telework arrangements must receive approval from the Appointing Authority or his/her designee. Situational telework arrangements do not require an additional amended GOEA Telework Agreement Form unless the employee's arrangement will exceed 30 days.*		

Telework Terms and Conditions

1. All teleworkers are responsible for obtaining reliable phone service and high-speed internet connections. These connections must be maintained for the duration of the teleworking agreement.

2. All teleworkers shall be connected to the GOEA Virtual Private Network (VPN) at all times while performing work from their state-owned laptops at the alternative worksite.

3. The amount of time a teleworker is expected to work will not change due to voluntary participation in a telework-formal or telework-situational arrangement. Telework hours are regular work hours and may not be used for personal activities. All teleworkers are expected to remain accessible during designated work hours. Just as with regular work hours, teleworkers are expected to follow the GOEA Time and Attendance Policy as it relates to requesting time off. In the event that overtime is anticipated, this must be discussed and approved in advance with the supervisor/manager, just as any overtime scheduling would normally have to be approved.

4. All teleworkers will report to the primary worksite, as necessary, upon directive from management.

5. All teleworkers shall use the time and attendance system to input telework via the "ZTEL" time code.

Employee Approval

I agree to abide by the terms and conditions set forth in this GOEA Telework Agreement Form and all requirements of the GOEA Telework Policy.

I understand that management has the right to amend, terminate or suspend this Agreement at any time.

I understand that failure to comply with the provisions of this Agreement and the GOEA Telework Policy may result in termination of the Agreement, and/or other appropriate corrective measures.

I understand that my alternative worksite is an extension of my assigned primary worksite. As such, I am responsible for continuing to comply with all applicable laws, rules, regulations, and policies regarding my position and my employment at GOEA.

I understand that this agreement is not finalized until it is approved by the Appointing Authority or his/her designee.

Employee Signature	Date
Supervisor/Manager Signature	Date
Appointing Authority Signature	Date

Galvez Parking Garage Access

First Name	
Last Name	
Email Address	
Phone Number	
Vehicle 1 Year	
Vehicle 1 Make	
Vehicle 1 Model	
Vehicle 1 Color	
Vehicle 1 License Plate Number	
Vehicle 1 License Plate State	
Vehicle 2 Year	
Vehicle 2 Make	
Vehicle 2 Model	
Vehicle 2 Color	
Vehicle 2 License Plate Number	
Vehicle 2 License Plate State	

Required Courses for New Hire/Rehire

SuccessFactors

www.leo.doa.louisiana.gov/

- LA Code of Governmental Ethics (Required Annually by July 15th)
- SCS CPTP PES Basics (Upon Hire)
- LaGov CATS Time Entry (Upon Hire)
- SCS CPTP Prohibited Political Activity (Upon Hire)
- SCS CPTP Cybersecurity Awareness
- SCS CPTP Teleworking for Employees

SAFETY

- ORM Blood-borne Pathogens (Required every 5 years)
- SCS CPTP Preventing Sexual Harassment (Required Annually)
- ORM Defensive Driving (Required upon hire, every 5 years, and within 90 days of a chargeable incident)

Governor's Office of Elderly Affairs
State of Louisiana

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GOVERNOR

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Governor's Office of Elderly Affairs

SEXUAL HARASSMENT
NOTICE OF PERSONAL LIABILITY

Louisiana law requires government agencies to develop and implement policies and related training to prevent sexual harassment in the workplace. The prohibitions and requirements within these policies apply to all public servants -- employees, appointees and elected officials.

Louisiana's taxpayers have been financially burdened by judgments and settlements arising from claims of workplace sexual harassment. To reduce this impact, La. R.S. 42:351 et seq., enacted in the 2019 Regular Session (Act No. 413), declares that consideration be given to requiring that a public servant, once determined to have engaged in sexually inappropriate workplace behavior, personally reimburse all or a portion of any judgment or settlement resulting from such behavior. La. R.S. 42:353 sets forth the process and factors to be considered in making this determination, and authorizes the Attorney General to file suit against a public servant to enforce the state's right to reimbursement and indemnification.

Notice of this potential personal liability is disseminated by GOEA, along with our policy prohibiting sexual harassment, during orientation to every newly hired public servant. This notice also is disseminated, on an annual basis, to every existing GOEA employee. Reference to this potential personal liability also is included in the annual CPTP training on sexual harassment available through LEO.