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 7am- 7pm		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. <u>I am not required to pay</u> this tax.

_______ I have not been continuously employed in state government since April 1, 1986. <u>I am required to pay</u> 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

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

Date: ______________________

New ___ Revised ___

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:	

(Print full name)

I ________________________________ 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 10/31/2022

▶START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	- -		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________
OR
2. Form I-94 Admission Number: ____________
OR
3. Foreign Passport Number: ____________
Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):
☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: ______________ ***(See instructions for exemptions)***

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

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	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 document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

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 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: 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 alien's nonimmigrant status 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. 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		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 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 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 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		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. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 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. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

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

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)

07/01/2011
DA 2054
Supp.-1

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

2023

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
	City or town, state, and ZIP code		
	(c) ☐ **Single or Married filing separately** ☐ **Married filing jointly or Qualifying surviving spouse** ☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, other details, and privacy.

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) Reserved for future use.

(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 . . . . ☐

TIP: If you have self-employment income, see page 2.

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 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 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 2023 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, 2024.

Your privacy. If you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

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 roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.

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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 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.

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 2023 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:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 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 $ ____________

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	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

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

State of Louisiana

OFFICE OF THE GOVERNOR

Office of Elderly Affairs

John Bel Edwards

Governor

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

Name: ______________________________ Date ______________________________

Agency/Department: ______________________________ Position: ______________________________

LOUISIANA SECOND INJURY FUND
POST OFFER, PRE-EXISTING CONDITIONS, INJURIES OR ILLNESSES
MEDICAL INQUIRY (E-2)

NOTICE TO EMPLOYEES:

Your employer is committed to providing Workers' Compensation benefits, in accordance with state law, if you sustain an employment-related injury. This form requests medical information and will be kept confidential and separate from your personnel file. It will be used only in the event you experience a work-related injury and become eligible for Workers' Compensation benefits. The employer requires that all employees complete this questionnaire upon hire and every two years thereafter. The information is needed because if a work-related injury or disability is caused or made worse by a pre-existing condition, your employer may be able to seek reimbursement of the benefits paid from the Louisiana Second Injury Fund. This reimbursement would not reduce your workers' compensation benefits. In order to be considered for reimbursement, an employer must show it knowingly hired or knowingly retained an employee with a pre-existing disability. Disclosure of a pre-existing condition shall not be used for any discriminatory purpose. **THE FAILURE TO ANSWER TRUTHFULLY ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION BENEFITS UNDER LA. R.S. 23:1208.1.**

SECTION 1: DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Do not leave any blank unanswered. Please provide explanations for all "yes" responses under Remarks.

YES	NO	
☐	☐	Amputation (foot, leg, arm, hand, or total loss thereof)
☐	☐	Ankylosis of Joints
☐	☐	Arteriosclerosis
☐	☐	Arthritis
☐	☐	Asbestosis
☐	☐	Asthma
☐	☐	Back/Neck Problem
☐	☐	Brain Damage
☐	☐	Bronchitis
☐	☐	Cancer
☐	☐	Cardiac Disease
☐	☐	Carpal Tunnel Syndrome
☐	☐	Cerebral Vascular Accident
☐	☐	Chronic Headaches
☐	☐	Chronic Osteomyelitis
☐	☐	Compressed Air Sequelae
☐	☐	Diabetes
☐	☐	Dizziness
☐	☐	Double Vision (blurred sight)
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Head Injury
☐	☐	Heart Condition
☐	☐	Heavy Metal Poisoning
☐	☐	Hemophilia
☐	☐	High/Low Blood Pressure
☐	☐	Loss of Use of Limbs
☐	☐	Mental Disorders
☐	☐	Mental Retardation
☐	☐	Multiple Sclerosis
☐	☐	Muscle, Ligament or Tendon Injury
☐	☐	Muscular Dystrophy
☐	☐	Nervous Disorders
☐	☐	Numbness of Extremities
☐	☐	Parkinson's Disease
☐	☐	Psychoneurotic Disability (following treatment in a recognized medical or mental institution)
☐	☐	Reflex Sympathetic Dystrophy
☐	☐	Repetitive Motion Injury
☐	☐	Residual Disability from Polio
☐	☐	Rheumatism
☐	☐	Rotator Cuff Injury
☐	☐	Ruptured Intervertebral Disc
☐	☐	Silicosis
☐	☐	Spinal Fusion
☐	☐	Stroke
☐	☐	Sugar in Urine
☐	☐	Surgical Removal of Intervertebral Disc
☐	☐	Thrombophlebitis
☐	☐	Thoracic Outlet Syndrome
☐	☐	Thyroid Condition

☐	☐	Hodgkin's Disease	☐	☐	"Trick" Knee or Shoulder
☐	☐	Hyperinsulinism	☐	☐	Tuberculosis
☐	☐	Hypertension	☐	☐	Varicose Veins
☐	☐	Ionizing Radiation Injury			
☐	☐	Kidney Disorder			
☐	☐	Loss of Hearing (more than 75%)			
☐	☐	Loss of Sight (of one or both eyes or a partial loss of uncorrected vision)			

REMARKS: If you answered "yes" to any question above, indicate the nature of the injury/illness, name and address of the treating health care provider, area of specialty and approximate date/year of the illness/injury.

____

____

____

____

SECTION 2: PLEASE ANSWER THE FOLLOWING QUESTIONS AND PROVIDE AS MUCH INFORMATION AS POSSIBLE.

1. Has any doctor ever restricted your activities due to injury, disability or medical condition?

   ☐ YES ☐ NO

   If yes, please describe the reason for the restrictions, the type of restrictions, whether the restrictions were temporary or permanent, and whether you presently have any restrictions on your physical activities.

   ____

   ____

2. Have you ever been assessed any percentage of permanent disability to any part of your body?

   ☐ YES ☐ NO If yes, please explain:

   ____

   ____

3. Are you presently or have you ever been under the care of a doctor, chiropractor, or other health care provider for any serious injury, disability or medical condition?

   ☐ YES ☐ NO

   If yes, please list the condition, injury or illness(s) being treated, the name of the doctor(s), field of specialty, address and telephone number, and dates of treatment.

   ____

   ____

4. Are you presently or have you ever taken any medication for any serious injury, disability or medical condition?

   ☐ YES ☐ NO

   If yes, please list the name or type of medication, the medical condition being treated, and the name, address and telephone number of the physician who prescribed the medication, area of specialty, and dates of treatment.

   ____

   ____

5. Have you ever had surgery (other than cosmetic) to any part of your body ? ☐ YES ☐ NO

If yes, please list the part(s) of the body operated on, the type of operation performed, the date (or approximate date), the hospital, and the name, address, and phone number of the doctor performing the surgery (if known).

____

____

____

6. Have you ever received treatment for your head, neck, back or extremities (arms, wrists, legs, knees, etc.) from a doctor, chiropractor, physical therapist or other health care provider?

☐ YES ☐ NO

If yes, please list the name, address and phone number of all doctors, chiropractors, physical therapists, and other health care providers who provided such treatment, the dates of the treatment and the diagnosis provided.

____

____

____

7. Are you aware of any physical condition or injury that might impair or limit your ability to work in this position? ☐ YES ☐ NO If yes, please describe the condition or injury.

____

____

8. Have you ever received workers' compensation benefits for an injury that occurred at work?

☐ YES ☐ NO

If yes, please list the name of the employer, the nature of the injury and the dates, and the dates you received compensation.

____

____

I HAVE READ ALL __ PAGES OF THE LOUISIANA SECOND INJURY FUND POST OFFER OF EMPLOYMENT MEDICAL INQUIRY. I FULLY UNDERSTAND AND HAVE TRUTHFULLY AND FULLY ANSWERED ALL OF THE QUESTIONS, TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.

I UNDERSTAND THAT MY FAILURE TO TRUTHFULLY ANSWER ANY OF THE ABOVE QUESTIONS MAY RESULT IN THE FORFEITURE OF WORKERS' COMPENSATION AND MEDICAL BENEFITS UNDER THE LOUISIANA WORKERS' COMPENSATION STATUTE (LA.R.S. 23:1208.1).

SIGNATURE: ______________________ DATE: ______________

WITNESS: ______________________ DATE: ______________

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

This form is for Employer Use Only and should not be submitted to LASERS.

1-1
R0806

Louisiana State Employees' Retirement System
P.O. Box 44213, Baton Rouge, LA 70804-4213 • 225-922-0600 • Toll-Free 1-800-256-3000

Membership Registration

(Do not complete if Re-employed Retiree)

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

Member's First Name	Middle	Last	Today's Date (MM/DD/YYYY)	Social Security Number

IMPORTANT INFORMATION: Complete the entire form. Follow the specific instructions for each section. 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). Public Law 108-203, 108th Congress. A member may repay a refund to the system upon returning to state service and contributing to the system for eighteen months according to La. R.S.11:537 (D).

SECTION 1: MEMBER'S INFORMATION (To be completed by applicant)

A. Mailing Address (number, street or post office box) B. City State ZIP

C. Daytime Area Code/Telephone Number D. Evening Area Code/Telephone Number E. Member's Birthdate (MM/DD/YYYY) ☐ Male ☐ Female

F. Email address G. Would you like your address changed to the above listing, if it does not agree with the address on our records? ☐ Yes ☐ No

SECTION 2: DESIGNATION OF BENEFICIARY(IES)

Designation of Beneficiary(ies) – Complete Form 1-6 Designation of Beneficiary

SECTION 3: OPTIONAL MEMBERSHIP (TO BE COMPLETED ONLY IF AGE 55 OR OVER AND NOT A LASERS REHIRED RETIREE)

Check one of the two boxes below:

☐ At the time of employment I was age 60 or older and I elect to (please check option A, B, or C 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, B, or C 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
I understand that if I join the retirement system I must make employee contributions based on my earnings and that I must work a minimum of 10 years to be entitled to a monthly retirement benefit. If I work less than 10 years, I may make application for my employee contributions to be refunded to me without interest. 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 (7.65 percent Medicare included)

C) ☐ Join/maintain the Louisiana Deferred Compensation (at the minimum rate I would pay as a LASERS member)

SECTION 4: PREVIOUS ENROLLMENT

If you were at any time a member of LASERS, give the name under which the membership was reported. From (MM/DD/YYYY) To (MM/DD/YYYY)

If you are now, or at any time have been a member (including retiree) of another Louisiana public retirement system, please give the name under which the membership was reported. From (MM/DD/YYYY) To (MM/DD/YYYY)

My current status with the Louisiana public retirement system listed above is: ☐ Active ☐ Inactive ☐ Refunded ☐ Retired
(See La. R.S. 11:22 B for the list of Louisiana state retirement systems.)

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

☐ I elect NOT to join LASERS ☐ JOIN LASERS: I shall pay employee contributions and work a minimum of 10 years to be entitled to a monthly benefit; otherwise, I will only be eligible to refund my contributions.

SECTION 5: AGENCY CERTIFICATION – Certified True and Correct

ENROLLMENT STATUS – CHECK ALL THAT APPLY.

1. SERVICE HISTORY

☐ New – first time enrolled in the Louisiana State Employees' Retirement System. Regular class members hired on or after July 1, 2006, will have a contribution rate of 8 percent with a retirement eligibility of ten years or more service at age 60 or thereafter (Act 75, 2006 Legislative Session).

☐ Return to service – previous member of LASERS, whether refunded or not, with a break in service.
- ☐ Regular class member who is a former member of LASERS, **DID NOT** refund contributions and will contribute at 7.5 percent.
- ☐ Regular class member who is a former member of LASERS, **DID** refund contributions and will contribute at 8.0 percent.

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

☐ 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 eligible employment with all reporting agencies and are mandatory.

2. TYPE OF EMPLOYMENT

A. Classes 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.

1. Part-time employee – (26 CFR) works 20 hours or less per week
   a. Under La. R.S. 11:403 (20) any employee who is a part-time, seasonal, or temporary employee
   b. Can be on a Job Appointment
2. Intermittent – (La. R.S. 11:403 (14)) working an indefinite schedule on an "as needed" basis
   a. Can be on a WAE
3. Temporary – (26 CFR) working 2 years or less
   a. Restricted – (Civil Service Rule 8.10) working not to exceed a cumulative total of six months in a calendar year
   b. Job Appointment
4. Emergency – (Civil Service Rule 8:10) for work of a temporary nature to address an emergency or work overload situation
5. Job Appointment – (La. R.S. 11:403 (15)) working for a fixed period not to exceed two years
6. Seasonal – (26 CFR) works on a full-time basis less than five months in a year

B. Classes of Employees Eligible
1. Full-time – working over 20 hours per week
2. Job Appointment – working two years and one day or longer

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

☐ Part-time: This employee will work ______ hours per week

☐ Job Appointment working 2 years or less ☐ Job Appointment working 2 years and one day or longer

3. ☐ Permanent employee ☐ Temporary employee

3. EARNINGS REPORTING

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

4. CURRENT HIRE DATE

This is the first day with employment compensation as it applies to this agency.

Employee Position Tile ______ Hire Date (MM/DD/YYYY) ______ ☐ Classified ☐ Unclassified

5. NON-ISIS AGENCY

Attach a copy of the Social Security card and Birth Certificate.

THIS FORM IS A MULTI-PAGE DOCUMENT, AND I HAVE READ AND UNDERSTAND THIS FORM.

Certified True and Correct: Authorized Agency Representative Signature ______ Print Authorized Agency Representative Name ______ Title ______

Full Agency Name ______ Signing Representative's area code/telephone number ______ LASERS 3-digit Agency Number ______

Form 1-06
R082010

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

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	E-mail Address	Member's Birth Date

Check at least one:
- ☐ Active Member
- ☐ Retired Member - Retirement Benefit
- ☐ Retired Member - DROP/IBO Account

☐ Single ☐ Married ☐ Divorced ☐ Widowed

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 unpaid upon death 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" means if all of the designated primary beneficiaries die before the member does, any ordinary death benefit payable on the member's behalf, shall be paid to the contingent beneficiary(ies). If you have a "Power of Attorney" or other legal documents, you must submit a Certified copy. A COPY OF THE SOCIAL SECURITY CARD FOR EACH BENEFICIARY IS REQUIRED.

SECTION 3: DESIGNATION OF BENEFICIARY

PRIMARY BENEFICIARY'S PERCENTAGES MUST TOTAL 100%

Primary Beneficiary's Name (required)	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

Social Security Number

CONTINGENT BENEFICIARY'S PERCENTAGES MUST TOTAL 100%

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

SECTION 4: 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

Reset Form

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 <u>measurement</u> 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 <u>stability</u> 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 <u>must</u> 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 <u>must</u> 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/DELETE	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

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

IMPORTANT INFORMATION ABOUT BENEFICIARY DESIGNATIONS

Use this form to designate or make changes to the beneficiary(ies) of your Group Insurance death proceeds. The information on this form will replace any prior beneficiary designation. You may name anyone or any entity as your beneficiary and you may change your beneficiary at any time by completing a new Group Insurance Beneficiary Designation/Change form. Common designations include individuals, estates, corporation/organizations and trusts. **Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract.**

DEFINITIONS

You may find the following definitions helpful in completing this form:

Primary Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds. Payment will be made in equal shares unless otherwise specified. In the event that a designated primary beneficiary predeceases the insured, the proceeds will be paid to the remaining primary beneficiaries in equal shares or all to the sole remaining primary beneficiary.

Contingent Beneficiary(ies) – the person(s) or entity you choose to receive your life insurance proceeds if the primary beneficiary(ies) die (or the entity dissolves) before you die. Payment will be made in equal shares unless otherwise specified. In the event that a designated contingent beneficiary predeceases the insured, the proceeds will be paid to the remaining contingent beneficiaries in equal shares or all to the sole remaining contingent beneficiary.

INSTRUCTIONS FOR DESIGNATING A PRIMARY OR CONTINGENT BENEFICIARY

1. EMPLOYEE INFORMATION

- All information in this section is required.
- Unless otherwise indicated in Section 1, the information supplied on the form will apply to ALL coverages offered under the employer's group plan.
- Unless otherwise indicated in Section 2, the information supplied on the form will apply to all the Group Life coverage(s) issued by The Prudential Insurance Company of America to the group contract holder.

2. BENEFICIARY DESIGNATION

- You may name more than one primary and more than one contingent beneficiary. This form allows you to name up to four primary and four contingent beneficiaries. If you need additional space, please attach a separate sheet of paper.
- Please indicate the percentage share designated to each primary beneficiary. **The total for all primary beneficiaries must equal 100%.** If no percentages are specified, the proceeds will be split evenly among those named. Payment will be made to the named beneficiary. If there is no named beneficiary, or the named beneficiary predeceased the insured, settlement will be made in accordance with the terms of your Group Contract. **If designating percentages for contingent beneficiaries, the percentage for all contingent beneficiaries must also equal 100%.**
- You can name an individual, corporation/organization, trust, or an estate as a beneficiary. The following examples may be helpful in designating beneficiaries:

Individual: "Mary A. Doe"
- Each name should be listed as first name, middle initial, last name ("Mary A. Doe," not "Mrs. M. Doe")
- Include the address, telephone number, social security number, relationship and Date of Birth for each individual listed.
- Indicate the percentage to be assigned to each individual.

Estate: "Estate of the Insured"
- Select "Other" as the Beneficiary Description and write "Estate" in the blank space provided.
- Indicate the percentage to be assigned to the Estate of the Insured.

Corporation/Organization: "ABC Charitable Organization"
- Select "Corporation/Organization." as the Beneficiary Description.
- Write the legal name of the corporation or organization in the space for the Beneficiary's First Name.
- Include the address, city and state, telephone number and tax ID number of operation for each organization or corporation listed.
- Indicate the percentage to be assigned to the corporation or organization.

Trust: "The John Doe Trust. A Trust with a trust agreement dated 1/1/99 whose Trustee is Jane Smith."
- Select "Trust" as the Beneficiary Description.
- Indicate the percentage to be assigned to the trust.
- Complete Section 3, Trust Designation.

3. TRUST DESIGNATION

- Complete this section if you have named a trust as a primary or contingent beneficiary in Section 2. Fill in the name and address for each trustee.
- Fill in the title and date of the Trust Agreement in the space provided.

4. AUTHORIZATION/SIGNATURE

- The employee must read, sign and date the authorization.
- Submit the completed form to your Benefits Administrator or Human Resources (as directed by your employer) and keep a copy for your records.

Prudential

Group Insurance Beneficiary Designation/Change

DATE: ____/____/____

1. EMPLOYEE INFORMATION (please print)

Last Name	First Name	MI	Employee ID# (if applicable)	Marital Status (check one) ☐ Married ☐ Widowed ☐ Single ☐ Divorced	Gender (check one) ☐ Male ☐ Female	Has this insurance been assigned? ☐ Yes ☐ No

Address	City	State	ZIP Code	Daytime Phone	Home Phone	Date of Birth	Date of Hire	Date of Retirement (if applicable)

Name of Employer/Group Policyholder	Group Policy No.	Unless otherwise indicated below, this Beneficiary Designation/Change form applies to ALL coverages offered under my employer's group plan. This form applies only to ☐ Basic Life ☐ Basic AD&D ☐ Optional Term Life ☐ Optional AD&D ☐ GUL ☐ GVUL coverage(s).

2. BENEFICIARY DESIGNATION: I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies), if any, and in the event of my death, designate the following:

A. Primary Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
							TOTAL: (Must equal 100%)		

B. Contingent Beneficiaries

Beneficiary Description (check one)	First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	SSN/Tax ID Number	Phone	% Share
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
☐ Individual ☐ Other ______ ☐ Trust ☐ Corporation/Organization									
							TOTAL: (Must equal 100%)		

3. TRUST DESIGNATION - COMPLETE IF A TRUST HAS BEEN NAMED AS A BENEFICIARY IN SECTION 2

Trustee's Name (First, MI, Last)	Address (include city, state, ZIP)

And successor(s) in trust, as Trustee(s) under ______________________ **dated** ______________ **as amended and executed by me and said Trustee.**

Title of Agreement — Date of Agreement

Prudential

Group Insurance Beneficiary Designation/Change

4. **AUTHORIZATION/SIGNATURE** I authorize my plan administrator to record and consider the individuals/institutions that I have named on this form as beneficiaries for benefits under the applicable employee benefit plans. If designating a trust as a beneficiary, I understand Prudential assumes no obligation as to the validity or sufficiency of any executed Trust Agreement and does not pass on its legality. In making payment to any Trustee(s), Prudential has the right to assume that the Trustee(s) is acting in a fiduciary capacity until notice to the contrary is received by Prudential at its Group Life Claim office. I agree that if Prudential makes any payment(s) to the Trustee(s) before notice is received, Prudential will not make payment(s) again.

Employee's Signature X________________________ Date Signed ______________

The employee must sign and date this form. The signature date must be the date the employee actually signed the form.

Group Life coverage(s) are issued by The Prudential Insurance Company of America, a New Jersey company, 751 Broad Street, Newark, NJ 07102. Group Variable Universal Life Insurance is distributed by Prudential Investment Management Services LLC, 655 Broad Street, 19TH Floor, Newark, NJ 07102, a registered broker/dealer and a Prudential Financial company. 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. Contract provisions may vary by state. Contract series: 83500 (Term Life), 89579 (Group Variable Universal Life), 96945 (Group Universal Life).

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

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 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 1-855-687-2021.*

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 = $23.52). **
- In Box #5, indicate the FSA fee per pay period (paid biweekly is $0.98; paid monthly is $1.96). ***

*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; $3,050 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; $3,050 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.

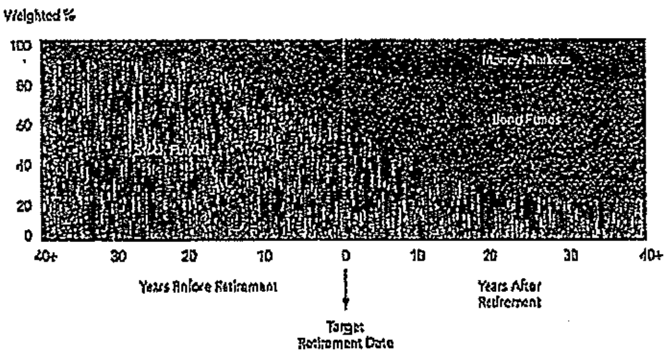
If you enroll for the first time but don't choose any investment options, you will be defaulted into a BlackRock LifePath Fund[2] based on your date of birth (*see the chart below*). Target date funds are a diversified mix of underlying funds whose asset allocations change over time to become more conservative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

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)

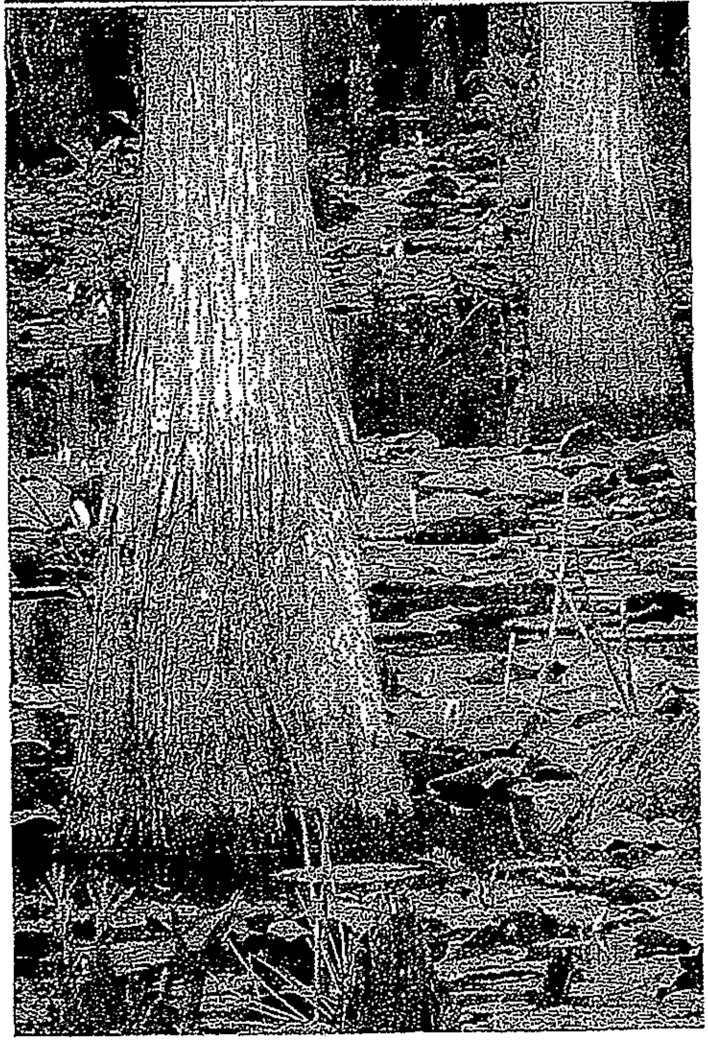
▶ HOW DO I GET MORE INFORMATION?

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



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:		

Rev. 6/2022

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)