Income Tax Forms and Instructions

Walker County Commission cannot give legal or financial advice. Below are some websites that may be of assistance. If you need assistance contact a financial advisor or accountant.

www.irs.gov

https://www.revenue.alabama.gov/individual-corporate/individual-income-estimated-taxes/

https://www.irs.gov/individuals/tax-withholding-estimator

https://smartasset.com/taxes/alabama-tax-calculator

https://www.youtube.com/watch?v=X5qPHKTDH0g (Alabama A-4)

Included in packet:

Form A4---Alabama withholdings

Form W-4—Federal withholdings

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

City or town, state, and ZIP code

Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.

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

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

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** $ ________

FORM
A4
(REV. 3/2014)

ALABAMA DEPARTMENT OF REVENUE
50 North Ripley Street • Montgomery, AL 36104 • InfoLine (334) 242-1300
www.revenue.alabama.gov

ALABAMA GREAT SEAL

Employee's Withholding Tax Exemption Certificate

Every employee, on or before the date of commencement of employment, shall furnish his or her employer with a signed Alabama withholding exemption certificate relating to the number of withholding exemptions which he or she claims, which in no event shall exceed the number to which the employee is entitled. In the event the employee inflates the number of exemptions allowed by this Chapter on Form A4, the employee shall pay a penalty of five hundred dollars ($500) for such action pursuant to Section 40-29-75.

Part I – To be completed by the employee

EMPLOYEE NAME				EMPLOYEE SOCIAL SECURITY NUMBER
STREET ADDRESS	CITY	STATE	ZIP CODE	

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. If you claim no personal exemption for yourself and wish to withhold at the highest rate, write the figure "0", sign and date Form A4 and file it with your employer.......... ______
2. If you are SINGLE or MARRIED FILING SEPARATELY, a $1,500 personal exemption is allowed. Write the letter "S" if claiming the SINGLE exemption or "MS" if claiming the MARRIED FILING SEPARATELY exemption .... ______
3. If you are MARRIED or SINGLE CLAIMING HEAD OF FAMILY, a $3,000 personal exemption is allowed. Write the letter "M" if you are claiming an exemption for both yourself and your spouse or "H" if you are single with qualifying dependents and are claiming the HEAD OF FAMILY exemption.......... ______
4. Number of dependents (other than spouse) that you will provide more than one-half of the support for during the year. *See dependent qualification below.*.......... ______
5. Additional amount, if any, you want deducted each pay period.......... $ ______
6. **This line to be completed by your employer:** Total exemptions (example: employee claims "M" on line 3 and "2" on line 4. Employer should use column M-2 (married with 2 dependents) in the withholding tables).......... ______

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

Employee's Signature ______________________ **Date** ______________

Part II – To be completed by the employer

EMPLOYER NAME				EMPLOYER IDENTIFICATION NUMBER (EIN)
Walker County Commission	Jasper			63-6001721
ADDRESS	CITY	STATE	ZIP CODE	
1801 3rd Ave South Ste 113	Jasper	AL	35501	

Employers are required to keep this certificate on file. If the employee is believed to have claimed more exemption than legally entitled or claims 8 or more dependent exemptions, the employer should contact the Department at the following address or phone number for verification: Alabama Department of Revenue, Withholding Tax Section, P.O. Box 327480, Montgomery, AL 36132-7480, by phone at (334) 242-1300, or by fax at (334) 242-0112. If the employee does not qualify for the exemptions claimed upon verification, the employer is required to withhold at the highest rate until the employee submits a corrected Form A4 reflecting the proper exemption they are entitled to claim.

DEPENDENTS: To qualify as your dependent (Line 4 above), a person must receive more than one-half of his or her support from you for the year and must be related to you as follows:

Your son or daughter (including legally adopted children), grandchild, stepson, stepdaughter, son-in-law, or daughter-in-law;
Your father, mother, grandparent, stepfather, stepmother, father-in-law, or mother-in-law;
Your brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law, or sister-in-law;
Your uncle, aunt, nephew, or niece (but only if related by blood).

Taxable Wages

		Federal W/H Taxable	FICA Taxable (SS & Medicare)	State W/H Taxable
ERS Retirement		YES	YES	YES
RSA-1 (457 Retirement Plan)		NO	YES	NO
Nationwide Retirement		NO	YES	NO
Cafeteria Plan (Section 125)		NO	NO	NO
Expense Allowance		YES	YES	YES
Clothing/Boot Expense		NO	NO	NO
Personal Usage Company Vehicle		YES	YES	YES

LGHIP

BCBS

HEALTH INSURANCE

Form LG01
Revised 8/22

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
ENROLLMENT FORM

EMPLOYEE INFORMATION (Please print or type)

Name (First, Middle Initial, Last)		Social Security Number	Date of Birth	Gender
Mailing Address		City	State	ZIP Code
Physical Address *Must be completed by Medicare Retiree Enrollee		City	State	ZIP Code
Primary Phone Number	Work Phone Number	E-mail Address:		

Employment Status (Check One)

☐ Full-time Employee ☐ ACA Eligible (Must submit Form LG23) ☐ Elected Official ☐ Retired (Not Medicare Participant) ☐ Retired (Medicare Participant)

Note: If you or your covered dependent(s) are covered by Medicare, you must submit a copy of your Red, White, and Blue Medicare Card and a physical address. Your name must match the name listed on your Medicare card.

Dependent Information - Documentation is required before dependents can be added to coverage. See back of form.

Dependent's Name (First, Middle, Last)	Relationship to Employee (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

Other Group Health Insurance Information

Do you have additional insurance coverage other than LGHIP coverage? ☐ Yes ☐ No

If yes, you must complete the Other Group Health Insurance Addendum on Page 3.

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the LGHIB's behalf.

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

_______________________________ Employee Signature
_______________________________ Date

TO BE COMPLETED BY EMPLOYER

Full-Time Date of Hire: __________ **Local Government Unit Name:** ______________________ **Unit Number:** ________

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.

Signature of Benefit Administrator: ______________________________ **Date:** ______________

Local Government Health Insurance Board
(334) 263-8326 • 1-866-836-9137
Enrollments@lghip.org

Other Group Health Insurance Addendum

Must be completed if you, your spouse and/or dependents have any other coverage.

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #

Name of Insurance Company	Types of coverage (Check all that apply)
	☐ Hospitalization ☐ Doctor's Visits
Name of Employer	☐ Prescription Drugs ☐ Dental

If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)

Rx BIN Number	Rx ID

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

LIST EACH INSURANCE COMPANY SEPARATELY (ATTACH ADDITIONAL SHEETS IF NECESSARY)

Name of Contract Holder	Contract Holder Date of Birth	Group #	Insurance Contract #

Name of Insurance Company	Types of coverage (Check all that apply)
	☐ Hospitalization ☐ Doctor's Visits
Name of Employer	☐ Prescription Drugs ☐ Dental

If other coverage includes prescription drug coverage, please complete the below (information can be found on your other coverage insurance card)

Rx BIN Number	Rx ID

Are you or any of your dependents covered on this insurance policy? ☐ Yes (list each covered individual below) ☐ No

Name(s) (First, Middle Name, Last)	Date of Birth	Coverage Effective Date(s)

Local Government Health Insurance Plan
JANUARY 1, 2023

This table is a summary of benefits and is subject to all other terms and conditions of the Plan.

To maximize your benefits, seek medical services from a Preferred Provider who participates in the BlueCard® Preferred Provider Organization (PPO) Program. To find out if your provider is a PPO member, call 1-800-810-BLUE (2583) or access the Blue Cross website, **AlabamaBlue.com**. Please be aware that not all providers participating in the BlueCard® PPO Program will be recognized by Blue Cross as approved providers for the type of service being furnished as explained more fully in the "Benefit Conditions" section of the Plan's hand book.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
INPATIENT HOSPITAL BENEFITS		
Precertification is required for inpatient admissions (except medical emergency, maternity and as required by Federal law); notification within 48 hours for medical emergencies. Generally, if precertification is not obtained, no benefits are available. Call 1-800-248-2342 for precertification.		
Inpatient Facility Coverage (including maternity)	Covered at 100% of the allowance, subject to a $200 per admission deductible and $50 copay per day for days 2-5	Covered at 80% of the allowance, subject to a $200 per admission deductible and $50 copay per day for days 2-5.
OUTPATIENT HOSPITAL BENEFITS		
Precertification is required for certain outpatient hospital benefits, including radiology services and a select group of provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available.		
Surgery	Covered at 100% of the allowance, subject to the $100 facility copay. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.	Covered at 80% of the allowance, subject to the calendar year deductible. Certain outpatient surgeries require pre-certification, call 1-800-248-2342.
Medical Emergency	Covered at 100% of the allowance, subject to the $200 facility copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical.	Covered at 100% of the allowance, subject to the $200 facility copay for treatment of sudden and severe symptoms that require immediate medical attention and meet medical emergency guidelines. Claims with emergency room charges that do not meet medical emergency guidelines will be covered under Major Medical.
Accidental Injury	Covered at 100% of the allowance with no deductible or copay	Covered at 100% of the allowance with no deductible or copay
Diagnostic X-rays & Tests	Covered at 100% of the allowance, subject to the $100 facility copay per visit or cost of service, whichever is less.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic Lab & Pathology Certain outpatient x-rays and tests require precertification, call 1-866-803-8002.	Covered at 100% of the allowance, subject to a $7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Dialysis, IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance, subject to the $25 facility copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Note: In Alabama, inpatient and outpatient benefits for non-member hospitals are available only in cases of accidental injury or medical emergency and covered as an out-of-network hospital.		
PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT BENEFITS		
Precertification is required for a select group of provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList. Call 1-800-248-2342 for precertification. If precertification is not obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Primary Care Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $40 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Specialist Physician Office Visits, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $50 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Nurse Practitioners / Nurse Midwives, Physician Assistant Office Visits, Registered Dietician, Office Surgery & Outpatient Consultations	Covered at 100% of the allowance, subject to the $20 office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.
Physician fees for Outpatient Surgery and Anesthesia (other than in a physician's office)	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Second Surgical Opinion	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Telephone and Online Video Consultations Program A telephone and online video consultation service available to diagnose, treat and prescribe medication (when necessary) for certain medical issues is available through Teladoc. Telephone and online video consultations are available 24 hours a day, 7 days a week.	Covered at 100% of the allowance; no copay or deductible	Not covered.
Emergency Room	Covered at 100% of the allowance, subject to the office visit copay.	Covered at 100% of the allowance, subject to the office visit copay.
Inpatient Visits	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Maternity	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
Lab & Pathology Exams	Covered at 100% of the allowance, subject to a $7.50 copay per test.	Covered at 80% of the allowance, subject to the calendar year deductible.
Diagnostic X-rays & Tests	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
IV Therapy, Chemotherapy & Radiation Therapy	Covered at 100% of the allowance; no copay or deductible	Covered at 80% of the allowance, subject to the calendar year deductible.
TELEHEALTH SERVICES		
Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.		
ROUTINE PREVENTIVE CARE		
Routine Immunizations and Preventive Services	Covered at 100% of the allowance with no deductible or copay. • See **AlabamaBlue.com/preventiveservices** for a listing of the immunizations and preventive services or call the BCBS Customer Service Department for a printed copy	Covered at 80% of the allowance subject to the calendar year deductible. • See **AlabamaBlue.com/preventiveservices** for a listing of the immunizations and preventive services or call Customer Service Department for a printed copy
Additional Routine Preventive Services	Covered at 100% of the allowance with no deductible or copay. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)	Covered at 80% of the allowance subject to the calendar year deductible. In addition to the standard, the following will apply: • Urinalysis (once by age 5, then once between ages 12-17) • CBC (once every 2 calendar years ages 6-17, then once every calendar year age 18 and over) • Glucose testing (once every calendar year age 18 and over) • Cholesterol testing (once every calendar year age 18 and over) • TB skin testing (once before age 1, once between ages 1-4, and once between ages 14-18)
MENTAL HEALTH SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
Inpatient Provider Services	Covered at 80% of the allowance, no copay or deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIP Outpatient Provider Services **(See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)**	**Approved LGHIP providers**: Covered at 100% of the allowance, subject to a $14 copay per visit; limited to 24 visits per person per calendar year. Other copays may apply based on services rendered. **Blue Choice Behavioral Network providers:** Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person per calendar year.
Residential Treatment Facilities for treatment of Eating Disorders	Covered at 80% of the allowance, subject to the calendar year deductible. Services must be approved by New Directions; precertification and ongoing medical necessity review required; limited to 60 days per member per calendar year	Covered at 80% of the allowance, subject to the calendar year deductible. Services must be approved by New Directions; precertification and ongoing medical necessity review required; limited to 60 days per member per calendar year

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
SUBSTANCE ABUSE SERVICES		
Inpatient Facility Services	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.	Covered at 80% of the allowance, subject to a $200 inpatient per admission deductible.
Inpatient Provider Services	Covered at 80% of the allowance; no copay or deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
LGHIP Outpatient Provider Services **(See Mental Health and Substance Abuse chapter in your plan book for more information on approved LGHIP providers.)**	**Approved LGHIP providers:** Covered at 100% of the allowance, no copay or deductible; limited to 40 visits per person per calendar year. **Blue Choice Behavioral Network providers:** Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.	Covered at 80% of the allowance, subject to the calendar year deductible; limited to 24 visits per person each calendar year.
MAJOR MEDICAL GENERAL PROVISIONS		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible	$200 per person each calendar year; maximum of three deductibles per family.	
Annual Out-of-Pocket Maximum	$9,100 individual annual out-of-pocket maximum; $18,200 family maximum. **In-Network Services:** Deductibles, copays and coinsurance for in-network services apply to the out-of-pocket maximum, including prescription drugs. For members up to age 19, deductibles and coinsurance for in-network dental services under the group dental benefits apply to the out-of-pocket maximum. **Out-of-Network Services:** Do not apply to the out-of-pocket maximum. After you reach your Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowance for remainder of the calendar year.	
MAJOR MEDICAL SERVICES		
Precertification is required for certain major medical services and a select group of provider administered drugs; please see benefit booklet. Call 1-800-248-2342 for precertification. If no precertification is obtained, no benefits are available. For provider-administered drugs listed on AlabamaBlue.com/Providers/HealthSmartRx, cost share may vary based on available manufacturer assistance. Upon enrollment, cost share will be lowered or reduced to zero.		
Participating Chiropractor Services	Covered at 80% of the allowance with no deductible. Precertification is required after the 18th visit.	Non-Participating: Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 18th visit.
Applied Behavioral Analysis (ABA) Therapy	For children 18 years or younger, covered at 100% of the allowance after $14 copay per visit and subject to the following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter or for any member nearing the ABA annual maximum to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.	For children 18 years or younger, covered at 80% of the allowance subject to calendar year deductible and following annual maximum benefits: Age — Annual Maximum 0 to 9 — $40,000 10 to 13 — $30,000 14 to 18 — $20,000 Precertification is required prior to rendering ABA therapy to determine medical necessity. Precertification is also required every six months thereafter or for any member nearing the ABA annual maximum to determine medical necessity for continued therapy. If precertification is not obtained, coverage for all services associated with subsequent visits will be denied. For a complete listing of covered services and precertification requirements, please call 1-877-563-9347.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
Physical Therapy, Speech Therapy and Occupational Therapy related to the screening, diagnosis, and treatment of Autism Spectrum Disorder	For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	For children 18 years or younger, covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
Rehabilitative and Habilitative Physical Therapy, Speech Therapy and Occupational Therapy	Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule. Precertification is required after the 15th visit to determine the medical necessity for continued therapy. Call 1-800-248-2342 for precertification. If precertification is not obtained, coverage for all services associated with the 16th and subsequent visits will be denied.
Durable Medical Equipment	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
Ground Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
Air Ambulance Services	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible.
Allergy Testing & Treatment	Covered at 80% of the allowance, subject to the calendar year deductible.	Covered at 80% of the allowance, subject to the calendar year deductible. Member is responsible for the 20% coinsurance and any amount billed over the fee schedule.
Home Health Services	Covered at 80% of the allowance, subject to the calendar year deductible, when services are rendered by a participating Home Health agency; Precertification is required; call 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required; call 1-800-821-7231. In Alabama: No coverage for services rendered by a non-participating Home Health agency.
Home Infusion Services	Covered at 100% of the allowance, subject to the $25 office visit copay when services are rendered by a participating Home Infusion Service Provider; Precertification is required for provider-administered drugs; call 1-800-821-7231.	Outside Alabama: Covered at 80% of the allowance, subject to the calendar year deductible. Precertification is required for provider-administered drugs; call 1-800-821-7231. In Alabama: No coverage for services rendered by a non-participating Home Infusion Service Provider.
Diabetic Education	Covered at 100% of the allowance with no deductible; limited to five diabetic classes (in an approved diabetic education facility) per person within a six-month period for any diabetic diagnosis (not held to insulin dependent diabetics); services in excess of this maximum must be certified through case management; call 1-800-248-2342.	Not covered.
Medical Nutrition Therapy For Adults and Children, 6 hours per member per calendar year	Covered at 100% of the allowance, subject to the applicable office visit copay.	Covered at 80% of the allowance, subject to the calendar year deductible.

BENEFIT	IN-NETWORK (PPO)	OUT-OF-NETWORK (NON-PPO)
PRESCRIPTION DRUGS		
Prescription drug benefits are covered through OptumRx®. For more information, call OptumRx Member Services at 1 844-785-1603 or visit the website at www.OptumRx.com.		
TIER 1 DRUGS (PRESCRIPTION DRUG CARD PROGRAM) • Generic non-maintenance drugs may be dispensed up to a 30-day supply. • Generic maintenance drugs may be dispensed up to a 60-day supply, for one $15 copay, after an initial 30-day supply fill. • The plan utilizes the OptumRx Premium Formulary; however, plan benefits will supersede the Premium Formulary drug list.	Covered at 100% of the allowance subject to a $15 copay per prescription	No benefits are available for prescriptions purchased at a non-participating pharmacy.
TIER 2 AND TIER 3 DRUGS (POINT OF SALE DRUG PROGRAM) • Brand drugs (Tier 2 and Tier 3) may be dispensed up to a 90-day supply. Member must pay the cost of the drug and file a claim for reimbursement. • The prescription receipt (not the register receipt) is required for reimbursement requests. See the Prescription Drugs Chapter in the Planbook for additional receipt requirements. • Specialty drugs can be dispensed for up to a 30-day supply. The only in-network pharmacy for some specialty drugs is the Optum Specialty Pharmacy. Call Optum Specialty Pharmacy at 1-855-427-4682 for more information.	Covered at 80% of the allowance after being submitted for reimbursement. Subject to the calendar year deductible of $200.	No benefits are available for prescriptions purchased at a non-participating pharmacy.
HEALTH MANAGEMENT BENEFITS		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231 and press 7.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions. For more information, please call 1-833-964-1448 and press 0.	
Baby Yourself®	A maternity program that will waive the hospital deductible and daily copays for inpatient admission at delivery. For the waived hospital deductible and daily copays to apply, the member must enroll in the Baby Yourself program within the first two trimesters of pregnancy. Members may enroll at **AlabamaBlue.com/BabyYourself.** For more information, please call 1-800-222-4379.	

Note: Teladoc Health is an independent company that Blue Cross and Blue Shield of Alabama has contracted with to provide you with teleconsultation services. Blue Cross and Blue Shield of Alabama is an independent licensee of the Blue Cross and Blue Shield Association.

For precertification call 1-800-248-2342. Call Blue Cross and Blue Shield of Alabama at 1-800-321-4391. Visit the Local Government Health Insurance Board's website at www.lghip.org.

The LGHIP is a self-insured health benefits plan administered by the LGHIB. The LGHIP provides minimum essential coverage and meets the minimum value standard as defined by the Affordable Care Act.

This is not a contract, benefit booklet, or Summary Plan Description. Benefits are subject to the terms, limitations and conditions of the group contract. Check your benefit booklet for more detailed coverage information. Please visit our website at www.AlabamaBlue.com.

Revised 11-21-22 AR
Group 30000
Effective January 1, 2023

Southland

Dental

Vision

Insurance

Website:www.southlandbenefits.com Group:2500

Local Government Dental Benefit Plan Benefit Summary

Effective January 1, 2023

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PREFERRED DENTAL

Blue Cross and Blue Shield of Alabama's Dental Network is a statewide dental network. This managed care program is designed to promote quality and cost effective dental care. Currently more than 1,834 dentists, approximately 93% of the dentists in Alabama, have joined this program.

Dental Network Provisions:

- Network dentists will file all claims and accept the Blue Cross payment as payment in full (after any deductible and coinsurance you owe).
- Payments for covered services provided by in-network dentists in Alabama are based on the dental network fee schedule that offers an average savings of approximately 20% off billed charges.
- Payments for covered services provided by out-of-network dentists in Alabama will be made according to the dental network fee schedule at the same level as in-network services. However, you may be responsible for the difference between the Blue Cross payment and the dentist's charge (plus any deductible and coinsurance). You may also have to file the claim if your dentist's office will not.
- Payments for covered services received outside Alabama will be paid at the lesser of the amount Blue Cross will recognize as the "allowed amount" or the amount charged by the dentist.
- To find a network dentist, go to **AlabamaBlue.com** and click on "Find a Doctor". Then, select "Dentist" for healthcare provider type and enter a search location or call customer service at 1.800.321.4391.

The Managed Dental Network - another reason why Blue Cross and Blue Shield of Alabama is the leader in managed care.

PREFERRED DENTAL BENEFITS

BENEFITS	PREFERRED	NON-PREFERRED
Deductible	$25 per member each calendar year; Maximum of three deductibles per family.	$25 per member each calendar year; maximum of three deductibles per family. Member responsible for any difference between billed charge and fee schedule reimbursement.
Diagnostic & Preventive Services	Covered at 100% of the Preferred Dental Fee Schedule with no deductible.	Covered at 100% of the Preferred Dental Fee Schedule with no deductible. Member responsible for any difference between billed charge and fee schedule reimbursement.
Basic & Major Services (Fillings, Oral Surgery, Periodontics, Endodontics, Prosthodontics)	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible.	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible. Member responsible for any difference between billed charge and fee schedule reimbursement.
Orthodontic Services	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible. No dollar limit for medically necessary services for members under age 19*. All other services limited to a separate lifetime maximum of $1,000 per person. Coverage available to Dependent Children under age 19 **only***.	Covered at 50% of the Preferred Dental Fee Schedule subject to a $25 annual deductible. No dollar limit for medically necessary services for members under age 19*. All other services limited to a separate lifetime maximum of $1,000 per person. Coverage available to Dependent Children under age 19 **only***. Member responsible for difference in billed charges and allowed fee schedule.
Annual Benefit Maximum	No maximum for members under age 19*. $1,500 per member age 19 and over for all covered services.	
Annual Out-of-Pocket Maximum	For members under age 19*, deductibles and coinsurance for in-network (preferred) dental services will apply to the annual health in-network out-of-pocket maximum.	

*Applicable pediatric dental benefits apply to members through the end of the month in which the member turns 19.

This is not a contract. Benefits are subject to the terms, limitations and conditions of the group contract.

Revised 11-16-22 AR
Groups 30000 and 97000 LW

Form LG07
Revised 9/22

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
ENROLLMENT FORM
SOUTHLAND VOLUNTARY INSURANCE

SUBSCRIBER INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)		Gender
Social Security Number		Date of Birth
Mailing Address		
City	State	ZIP Code
Primary Telephone Number ( )	Work Telephone Number ( ) Ext:	
E-mail Address:		

CHECK PLAN ELECTED

☐ Vision — $12/ Single $20/Family

☐ Dental — $44/ Single $44/Family

☐ Vision and Dental — $56/ Single $64/Family

A minimum enrollment of 12 months required for employees/ dependents without qualifying status change.

Employment Status (Check One)

☐ Full-time Employee ☐ ACA Eligible (Must submit form LG23) ☐ Elected Official ☐ Retired (Not Medicare Participant) ☐ Retired (Medicare Participant)

NOTE: BY LISTING FAMILY MEMBERS BELOW YOU ARE APPLYING FOR AND REQUESTING FAMILY COVERAGE.

First Name	Initial	Last Name	Relationship to Employee (Male or Female Spouse, Son, Daughter, Stepson, Stepdaughter, Male or Female Custodial Dependent)	Date of Birth	Social Security Number

AFFIRMATION AND RELEASE

I hereby affirm that I have completely read and fully understand the terms and conditions of this form. I attest that all the representations made by me on this form are true and correct. I understand that any misrepresentation may result in the forfeiture of coverage and that I will be personally liable for all claims related to such misrepresentation. I further understand that there is mandatory utilization review and I do hereby give permission to release any information necessary to evaluate, administer, and process claims for benefits to any person, entity, or representative acting on the LGHIB's behalf.

I understand and acknowledge that only eligible dependents may be added to my coverage. I understand and acknowledge that it is my responsibility to notify the LGHIB immediately when the eligibility of a covered dependent changes. If it is determined that an act on my part (such as adding an ineligible person to coverage) or omission (such as failing to remove a person no longer eligible for coverage) results in or contributes to the payment of claims for persons ineligible for coverage, I will be personally responsible for all such overpayments and may be subject to disqualification from coverage under the plan.

______________________________ Employee Signature

______________________________ Date

TO BE COMPLETED BY EMPLOYER

Requested Effective Date*: ______________________________

**LGHIP may revise this date without notifying the unit if the requested date is incorrect*

Local Government Unit Name: ______________________________ **Unit Number:** ______________

If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.

Signature of Benefit Administrator: ______________________________ **Date:** ______________

Dependent documentation is required before dependents can be added to coverage.

GENERAL INFORMATION

Eligible Dependent

(Appropriate documentation must be attached.)

The term "dependent" includes the following individuals, subject to appropriate documentation (Social Security number, marriage certificate, birth certificate, court decree, etc.).

- The participant's spouse (excludes a divorced spouse)
- A child under age 26, only if the child is:
  - The participant's son or daughter
  - A child legally adopted by the participant or their spouse
  - The participant's stepchild
- A dependent, under age 19, for whom the participant, or his or her spouse, has been granted legal and physical custody by a court of competent jurisdiction
- An incapacitated child* over age 25 will be considered for coverage provided the dependent child is:
  - unmarried,
  - permanently mentally or physically disabled or incapacitated,
  - so incapacitated as to be incapable of self-sustaining employment,
  - dependent upon the participant for 50% or more financial support,
  - otherwise eligible for coverage as a dependent child except for age,
  - had the condition prior to the child's 26th birthday, and
  - not eligible for any other group insurance benefits.

  *The above requirements must be met to be eligible for coverage as an incapacitated child. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by BCBS. The LGHIB reserves the right to periodically recertify incapacitation. Neither a reduction in work capacity nor inability to find employment is, of itself, evidence of eligibility. If a mentally or physically incapacitated child is employed, the extent of their earning capacity will be evaluated.

  See the "Enrolling an Incapacitated Child" section for critical enrollment deadlines. If deadlines are not met, coverage may be denied.

Ineligible Dependents

An individual who does not meet the definition of an eligible dependent shall not be allowed to be covered as a dependent under the LGHIP. Examples include, but are not limited to:

- A participant's spouse or other dependents if they are independently eligible for coverage as an employee of a participating unit
- An ex-spouse, regardless of what the divorce decree may state
- Ex-stepchildren, regardless of what the divorce decree may state
- Children age 26 and older
- Foster children
- Incapacitated children age 26 and older who do not meet the Incapacitated Child eligibility requirements
- A child of a dependent child
- A participant's child, if the child has been adopted by someone other than their spouse and the participant has been relieved of their parental rights and responsibilities
- A daughter-in-law or son-in-law
- Grandchildren or other individuals related to the participant by blood or marriage for which the participant does not have legal custody
- Grandchildren or other children age 19 and older regardless of whether the participant has legal custody
- Grandparents
- Parents
- A fiancé or live-in girlfriend or boyfriend

Enrolling an Incapacitated Child

To apply, contact the LGHIB to obtain an Incapacitated Child Certification form. A completed Incapacitated Child Certification form and proof of incapacity must be provided to the LGHIB no more than 60 days after the dependent's 26th birthday*. If the form and proof of incapacity is not submitted within the required time, the child is not eligible for future enrollment except in the following two situations:

- When a new participant requests coverage for an incapacitated child within 60 days of employment; or
- When a participant's incapacitated child is covered under a spouse's employer group health insurance for at least <u>18 consecutive months</u> and:
  - the spouse loses the other coverage because:
    - the employer ceases operations, or
    - of termination of employment or reduction of hours of employment, or
    - the employer stopped contributing to coverage.

In these two situations, the child must meet all the Incapacitated Child eligibility requirements and submit an Incapacitated Child Certification form and a New Dependent form to the LGHIB within 60 days of the incapacitated child's loss of other coverage. The LGHIB will decide whether an application for incapacitated status will be accepted and final approval of incapacitation will be determined by medical review conducted by BCBS.

*The 60-day time limit does not apply to enrollment in a Southland Voluntary Plan.

VSP

Vision Insurance

Questions on plan: see Terry McKelvey

BCBS

Dental Insurance

Website: www.bcbsal.org Group:41851

Application

For Enrollment without Binding Arbitration

DENTAL COVERAGE

450 Riverchase Parkway East • P. O. Box 995
Birmingham, Alabama 35298-0001

BlueCross BlueShield of Alabama

ENR1-2110

BlueCross BlueShield of Alabama

Application For Enrollment

Fields marked with an * are required fields. Any required information not completed may delay the processing of your application.

EMPLOYEE INFORMATION

☐ DR. ☐ MR. ☐ MRS. ☐ MS. ☐ REV.

*HEALTH GROUP NUMBER

*HEALTH DIVISION NUMBER

*DENTAL GROUP NUMBER

*DENTAL DIVISION NUMBER

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER

*HOME MAILING ADDRESS

*CITY

*STATE

*ZIP

*PRIMARY TELEPHONE NUMBER ☐ HOME ☐ WORK ☐ CELL

( ) – –

ALTERNATE TELEPHONE NUMBER ☐ HOME ☐ WORK ☐ CELL

( ) – –

E-MAIL ADDRESS (Optional)

*GENDER ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

EMPLOYEE NUMBER

*PRIMARY PHYSICIAN NAME

*PHYSICIAN NPI

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*TYPE OF HEALTH COVERAGE SELECTED ☐ INDIVIDUAL ☐ FAMILY ☐ OTHER

*TYPE OF DENTAL COVERAGE SELECTED ☐ INDIVIDUAL ☐ FAMILY ☐ OTHER

DEPENDENT INFORMATION

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBERS.

NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.
By signing this application, you certify that all dependents are eligible for coverage under the terms of the Group Plan for which you are applying.

DEPENDENT

OUT OF AREA ☐ YES ☐ NO

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER ____________

*GENDER ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

*PHYSICIAN NPI

*PRIMARY PHYSICIAN NAME

DEPENDENT

OUT OF AREA ☐ YES ☐ NO

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER____________

*GENDER ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

*PHYSICIAN NPI

*PRIMARY PHYSICIAN NAME

DEPENDENT

OUT OF AREA ☐ YES ☐ NO

*LAST NAME

*FIRST NAME

MAIDEN/MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

*SOCIAL SECURITY NUMBER

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER____________

*GENDER ☐ MALE ☐ FEMALE

*DATE OF BIRTH (MM/DD/YYYY) / /

*PHYSICIAN NPI

*PRIMARY PHYSICIAN NAME

DEPENDENT OUT OF AREA ☐ YES ☐ NO

*LAST NAME	*FIRST NAME	
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER____	*GENDER ☐ MALE ☐ FEMALE	*DATE OF BIRTH (MM/DD/YYYY) / /
*PHYSICIAN NPI		
*PRIMARY PHYSICIAN NAME		

DEPENDENT OUT OF AREA ☐ YES ☐ NO

*LAST NAME	*FIRST NAME	
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	*SOCIAL SECURITY NUMBER
*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ OTHER____	*GENDER ☐ MALE ☐ FEMALE	*DATE OF BIRTH (MM/DD/YYYY) / /
*PHYSICIAN NPI		
*PRIMARY PHYSICIAN NAME		

If any dependent child above is over the applicable maximum age under your Group Plan and is incapacitated, please contact your Group Administrator to determine if coverage is available and/or obtain additional documents for completion.

STUDENT EXTENSION CERTIFICATION: If the Group Plan under which you are applying requires student certification, please list any dependent child applying for student extension.

NAME OF CHILD		NAME OF SCHOOL	
NAME OF CHILD		NAME OF SCHOOL	

NATURE OF APPLICATION*

☐ NEW CONTRACT	☐ CANCEL CONTRACT ☐ Medical Coverage ☒ Dental Coverage ☐ Medical & Dental Coverage	☐ CHANGE CONTRACT ☐ Name Change ☐ Address Change ☐ Type of Coverage Change	☐ ADD DEPENDENT ☐ Spouse ☐ Child ☐ REMOVE DEPENDENT ☐ Spouse ☐ Child REASON FOR REMOVAL ☐ Entry Into Military Service ☐ Divorce ☐ Death ☐ Request

ENROLLMENT EVENT TYPE

☐ Regular Enrollment ☐ Marriage ☐ Birth/Adoption ☐ Loss of Coverage
☐ Other ____

DATE EVENT OCCURRED (MM/DD/YYYY) / /

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person to be insured be covered under another health and/or dental plan or policy at the time this policy becomes effective? If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT	EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY) / /	
NAME OF INSURANCE COMPANY	EMPLOYER'S NAME	
POLICY, ID, CONTRACT OR CERTIFICATE NUMBER	GROUP NUMBER	TYPE COVERAGE ☐ INDIVIDUAL ☐ FAMILY

TRANSFER COVERAGE

A transfer of coverage occurs when you want to cancel one Blue Cross and Blue Shield of Alabama contract and enroll in another without a break in coverage. Please note that the transfer cannot occur prior to the date of employment. If you or your spouse are currently covered by a Blue Cross and Blue Shield of Alabama contract and wish to transfer to this group, please complete the information below.

CURRENT BLUE CROSS AND BLUE SHIELD OF ALABAMA CONTRACT NUMBER

MEDICARE BENEFITS INFORMATION

*LAST NAME	*FIRST NAME	
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	MEDICARE NUMBER

PART A ○	EFFECTIVE DATE (MM/DD/YYYY) / /	PART B ○	EFFECTIVE DATE (MM/DD/YYYY) / /
PART C ○	EFFECTIVE DATE (MM/DD/YYYY) / /	PART D ○	EFFECTIVE DATE (MM/DD/YYYY) / /

TO BE COMPLETED BY EMPLOYEE

☐ **I waive my right to benefits and do not wish to enroll. Employer should maintain this record in employee's file.**

☐ I am requesting cancellation of my existing benefits as checked above.

☐ I apply for the Group Health Benefits Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group agent or Remitting Agent. I ask my Group to pay you directly and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application.

You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for services to me. I ask that my doctor, hospital or anyone else gives my or my family's medical records to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health and/or dental policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I understand that I must follow the directions of my Primary Care Physician in order to receive the full contract benefits.

I acknowledge by my signature that I have read and understand the important information printed on the back of this application.

LAST NAME	FIRST NAME

MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)	SOCIAL SECURITY NUMBER
		___ - __ - ____

*SIGNATURE OF EMPLOYEE

____

DATE SIGNED (MM/DD/YYYY)	FULL-TIME EMPLOYMENT DATE (MM/DD/YYYY)
__ / __ / ____	__ / __ / ____

TO BE COMPLETED BY EMPLOYER

*EMPLOYER'S NAME	*GROUP NUMBER

EMPLOYER ADDRESS	EMPLOYER PHONE NUMBER
	(___)- ___ - ____

PRINTED GROUP ADMINISTRATOR NAME	GROUP ADMINISTRATOR EXTENSION
	X ____

*GROUP ADMINISTRATOR'S SIGNATURE	DATE SIGNED (MM/DD/YYYY)
	__ / __ / ____

Long-Term Disability

Voluntary Life

County Provided Life

$20,000

Need TWO (2) Beneficiaries with addresses and Social Security Number

Lincoln Financial Group

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **WALKERCOUN**	GROUP POLICY #:000010212055-00000 ; 000010212056-00000 ; 000400212057-00000	Billing Division or Location: 1556698

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) **Walker County Commission**		County	Employer ZIP	State
Employee Last Name / First Name / Middle Initial		Social Security Number		Date of Birth
Spouse Last Name / First Name / Middle Initial		Social Security Number		Date of Birth
Street Address		City / State		Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single	Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $________	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage		Amount of Coverage	Total Premium
		Basic Group Life/AD&D	☒Yes ☐No	**$20,000**	Employer Paid
		Long Term Disability	☐Yes ☐No*	$	$

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE		AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance	☐Yes ☐No*	$	$
Voluntary Employee Optional AD&D	☐Yes ☐No*	Equal to Life Insurance Amount	$
Voluntary Spouse Life Insurance	☐Yes ☐No*	$	$
Voluntary Spouse Optional AD&D	☐Yes ☐No*	Equal to Life Insurance Amount	$
Voluntary Dependent Child Benefit	☐Yes ☐No*	**$10,000**	$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

C. Beneficiary Information (Complete ONLY for Life/AD&D)

Primary Beneficiary's Last Name / First / MI	Relationship of Beneficiary	Social Security Number
Street Address	City / State	Zip
Contingent Beneficiary's Last Name / First / MI	Relationship of Beneficiary	Social Security Number
Street Address	City / State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

E. Request for Coverages
This coverage has been offered to me and after careful consideration of the benefits, I have decided to:
☑ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
☐ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
☐ **NOT ENROLL my dependents in the Program.** I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO RESTITUTION FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:______________________________ Employee Signature:_________________________ Date:_______________

Declination Forms

LGHIP

Letter of Credible Coverage

Form LG04
Revised 1/23

LOCAL GOVERNMENT HEALTH INSURANCE PROGRAM
NEW EMPLOYEE DECLINATION OF COVERAGE FORM

EMPLOYEE INFORMATION (Please print or type.)

Name (First, Middle Initial, Last)				Gender	Date of Birth
Social Security Number	**Contract Number**	**Primary Phone Number** ( )		**Work Phone Number** ( )	
Mailing Address		**City**		**State**	**Zip Code**

I, ____, wish to decline coverage in the Local Government Health
(name of local government employee)
Insurance Program. I affirm that I currently have other acceptable health insurance coverage* through ______________________________
(name of employer/company)

My other insurance carrier is:

NAME OF INSURANCE COMPANY:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER:		

***** *You must attach a current letter from employer/insurance carrier verifying coverage with the above-named carrier.*
A copy of your insurance card IS NOT acceptable as proof of coverage.

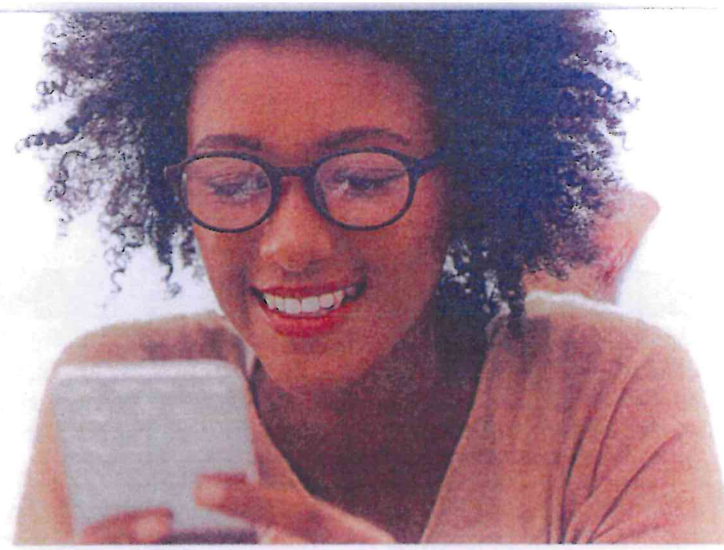
Employee Status: ☐ Full-time Employee ☐ ACA Eligible (Must submit form LG23) ☐ Elected Official

NOTICE: Eligible employees who decline coverage due to other acceptable coverage and then lose their other coverage must immediately notify the unit and enroll in the Local Government Health Insurance Plan. Coverage will be effective the date the other acceptable coverage ended. If the unit does not notify the LGHIB of the loss of other acceptable coverage and does not enroll the employee in the LGHIP, the unit will be responsible for any premiums due and will be billed retroactively to the date the eligible employee should have been enrolled (i.e. the date the other acceptable coverage ended).

Full-time Date of Hire:	**Employee Signature:**
Local Government Unit Name:	
Unit Number:	**Date:**
If signed electronically, I acknowledge and certify the electronic signature process complies with the Alabama Uniform Electronic Transaction Act and the LGHIB rules outlined in the Administrative Guide.	
Signature of Benefit Administrator:	

Local Government Health Insurance Board
(334) 851-6802 • 1-866-836-9137
Enrollments@lghip.org

FREQUENTLY ASKED QUESTIONS



At VSP Vision Care, we're dedicated to offering a benefit that's simple to use and worry-free. Here are answers to questions we're asked most about our services for members.

VSP MEMBER SERVICES

VSP Vision Care

QUESTIONS	ANSWERS
What's the best way to communicate and promote the VSP® benefit to members?	We have a variety of member communication tools designed to increase awareness and understanding of the VSP benefit. They're easy to read and provide all the benefit information members need. Please review the enclosed Member Communications Overview, and then contact the Client Support Team at **800.216.6248** for more information or to order the tools you need.
Do members need an ID card?	An ID card, or Member Vision Card, isn't required for members to receive services or care. Members simply call a VSP network provider to schedule an appointment, and tell them that they're a VSP member. The network provider and VSP handle the rest. If a member wishes to have an ID card, they can create an account and log on at **vsp.com** to print one.
How do members obtain a list of VSP network providers?	They should visit **vsp.com** or contact VSP at **800.877.7195**. Clients registered for the Manage Your Plan section at **vsp.com** can download customized VSP network provider lists as PDF or Excel files. Members and dependents have instant access through **vsp.com** to check coverage and eligibility, find a VSP network provider, and learn more about eye care wellness.
If members have questions about plan coverage, eligibility, or eye care wellness information, where should I direct them?	Members can also call VSP Member Services any time at **800.877.7195** or access our automated benefits information system to check eligibility or find a network provider. VSP Member Services is available Monday to Saturday, from 6:00 a.m. to 5:00 p.m., (Pacific Time); Closed on Sunday. ***Please note these new hours are effective January 1, 2022.***
Can we link our intranet or website to the VSP website?	Yes. To make it easy for members to find **vsp.com**, add the following code to your website: VSP.
What is my client ID number to register for the Manage Your Plan section?	You'll receive your client ID number with your welcome call or email. Each month's bill contains your client ID number, along with the active division and class number(s). Or, contact the Client Support Team at **800.216.6248** for your client ID number.

VSP

Enrollment Form with Dependent Data

Name of group (employer): WALKER COUNTY COMMISSION

Employee last name, first name, middle initial: ______________________

Social Security Number: ______________________

Gender: ☐ male ☐ female

Date of birth (month/date/year): ______________

Effective Date of Coverage: ______________

Type of coverage selected:
- ☐ employee only
- ☐ employee and one dependent
- ☐ employee and children
- ☐ employee and family
- ☐ waive coverage

* **Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	gender	* Dependent Relationship	date of birth mm/dd/yyyy
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	
			☐S ☐C ☐H ☐T	

Employee Signature: ______________________

Please return this form to your benefits administrator. Do not return to VSP.

RSA

RETIREMENT BENEFICIARY FORM

Designation of Beneficiary Prior to Retirement

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___   ___ ___   ___ ___ ___ ___

This form must be signed and notarized for changes to be activated. To name contingent beneficiaries, use the back of this form. If you name contingent beneficiaries, you must sign both sides of the form. Do not use this form if you are retired or participating in DROP. Please contact the RSA for the proper form.

Type of Account: ☐ TRS ☐ ERS ☐ JRF ☐ SNU Supernumerary members only

Your Information

Please note: Divorce or annulment of a marriage shall not revoke or void the designation of a spouse as beneficiary for any benefits payable by the RSA.

Name ______________________________
First | Middle/Maiden | Last

Address ______________________________
Street or P.O. Box | City | State | ZIP Code

Telephone Number ______________ Email Address ______________

Date of Birth ______________ Sex ☐ Male ☐ Female

Designation of Primary Beneficiary

Primary beneficiaries will receive any benefits payable upon the member's death.

If you have more than four primary beneficiaries, please contact the RSA.

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box | City | State | ZIP Code

Social Security Number ______________ Sex ☐ Male ☐ Female

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box | City | State | ZIP Code

Social Security Number ______________ Sex ☐ Male ☐ Female

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box | City | State | ZIP Code

Social Security Number ______________ Sex ☐ Male ☐ Female

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box | City | State | ZIP Code

Social Security Number ______________ Sex ☐ Male ☐ Female

☐ Check if contingent beneficiary information is continued on the back of this form.

Signature Certification

Sign Here →

Please have your signature acknowledged before a Notary Public.

Your Signature ______________________________ **Date** ______________

State of ______________, County of ______________

On this ______ day of ______________, 20 ________, personally appeared before me, the above named individual and acknowledged under oath that the statements made are true.

Signature of Notary Public ______________________________

Seal

My Commission Expires ______________________________

Designation of Beneficiary Prior to Retirement

If completing this side of the form, do not forget to sign at the bottom.

Name ______________________________ **SSN** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Designation of Contingent Beneficiary

Contingent beneficiaries will receive benefits only if all primary beneficiaries are deceased at the time of the member's death.

List any Contingent Beneficiaries below.

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

Social Security Number ______________________ Sex ☐ Male ☐ Female

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

Social Security Number ______________________ Sex ☐ Male ☐ Female

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

Social Security Number ______________________ Sex ☐ Male ☐ Female

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

Social Security Number ______________________ Sex ☐ Male ☐ Female

Sign Here → **Your Signature** ______________________________ **Date** ____________

**Page two must be signed if any contingent beneficiary information is submitted on this side of the form.*

RSA-1 Enrollment Packet

RSA-1 OF ALABAMA

Join RSA-1 and accelerate the growth of your retirement benefits!

RSA-1 is an eligible deferred compensation plan as defined by Section 457 of the Internal Revenue Code of the United States. The plan is authorized by § 36-27A-1, et. seq., *Code of Alabama 1975.* Under this deferred compensation plan, a public employee may elect to defer receipt of a portion of his or her salary until a later determined date, usually at retirement or termination of service. The deferred income is paid into the RSA-1 Deferred Compensation Plan and invested for the participant's benefit. Investment earnings are accumulated in the fund and are not subject to federal or state of Alabama income taxation until distributed to the employee. Deferred income and the investment earnings are held in the participant's account for the exclusive benefit of the plan participants and their beneficiaries.

START TODAY

This document includes the following forms:

» **RSA-1 Deferred Compensation Plan Enrollment**

» **RSA-1 and PEIRAF Beneficiary Designation**

» **RSA-1 Investment Option Election for New Accounts**

» **RSA-1 Authorization to Defer Compensation** (submit to your payroll officer)

IMPORTANT INFORMATION

» The RSA-1 Enrollment Packet must be submitted to RSA-1 with the first three forms completed.

CONTACT US

Please contact RSA-1 at 877.517.0020 if you have any questions.

Questions?

» **Visit RSA's website at www.rsa-al.gov**

» **Email RSA-1 through the RSA website; click on the "Contact" link at the top of the page**

» **Call RSA-1 at 877.517.0020**

The RSA-1 Deferred Compensation Plan
P.O. Box 302150 • Montgomery, Alabama 36130-2150 • 877.517.0020 • 334.517.7000 • www.rsa-al.gov

FORM INSTRUCTIONS

1. Complete the first three forms of the **RSA-1 ENROLLMENT PACKET**.
2. Submit the three completed forms to RSA-1 to establish an account. Deferrals should not be submitted until RSA-1 has received the RSA-1 DEFERRED COMPENSATION PLAN ENROLLMENT form.
3. Send the three forms of the **RSA-1 ENROLLMENT PACKET** to:

   The RSA-1 Deferred Compensation Plan
   P.O. Box 302150
   Montgomery, AL 36130-2150
4. Once an account is established, you initiate salary deferrals by completing the RSA-1 AUTHORIZATION TO DEFER COMPENSATION form with your payroll officer. You can only defer contributions to RSA-1 through payroll deductions. **Do not submit the RSA-1 AUTHORIZATION TO DEFER COMPENSATION form to RSA-1 or the RSA.** Contributions received by RSA-1 without executed enrollment forms will be refunded.

FREQUENTLY ASKED QUESTIONS

Q. Are my investment earnings taxed?

A. You do not pay income taxes on your investment earnings until they are withdrawn from RSA-1.

Q. Are there any limits on what I can contribute to RSA-1?

A. There is no minimum amount you may defer. If you are making deferrals to another 457 plan, an annual contribution maximum applies to all 457 plans. If you are contributing to a 403(b) or a 401(k), the limits to those plans will not be affected by deferrals to RSA-1.

Q. When can I withdraw my funds from RSA-1?

A. RSA-1 funds are available only after you have either retired or terminated employment.

Q. When I withdraw my funds, how are they taxed?

A. Distributions are subject to the withholding rules applicable to qualified plans. Deferred income and investment earnings distributed from RSA-1 will be taxed to the employee or beneficiary as ordinary income in the year of distribution and are reported on a FORM 1099-R in the year of distribution.

Q. Does RSA-1 accept rollovers or transfers?

A. RSA-1 accepts rollovers from state of Alabama or other eligible employer DROP, PLOP, or ERIP accounts once you have terminated employment. RSA-1 accepts trustee-to-trustee transfers from other 457 plans held by the participant. Funds transferred from other 457 accounts must never have been from any source other than 457(b).

Q. Can I roll over my RSA-1 funds to another plan?

A. Once you are eligible for distributions, you may roll over your RSA-1 funds to a Section 401(k), 403(b), 457 plan, Roth IRA, or a Traditional IRA. If still in service, you may transfer your RSA-1 funds to state of Alabama eligible 457 plans.

Q. Can I catch-up contributions for years I did not participate?

A. If you did not defer the maximum deferral amount in the years beginning with 1986 and were eligible to participate, you may "catch-up" unused eligible amounts, not exceeding the catch-up maximum, for one to three years if you are within three years of normal retirement age.

Q. May I defer my sick and annual leave?

A. If you are eligible to receive payment for sick and annual leave at termination of employment, you may defer up to the maximum limit in the year you terminate employment.

Q. Can I use my RSA-1 funds to purchase service credit with the ERS or TRS?

A. RSA-1 funds can be used to purchase permissive service credit with a governmental defined benefit plan such as ERS or TRS.

Q. Can I view my earnings online?

A. Yes, visit our website for monthly and historical returns or contact RSA-1.

OF ALABAMA

RSA-1 Deferred Compensation Plan

P.O. Box 302150
Montgomery, Alabama 36130-2150

334.517.7000 or 877-517-0020
www.rsa-al.gov

Enrollment Forms

- RSA-1 Enrollment (Submit to RSA-1)
- Beneficiary Designation (Submit to RSA-1) — Can also be used for change of beneficiary.
- Investment Option Election For New Accounts (Submit to RSA-1)
- Authorization to Defer Compensation (Submit to your payroll office)

RSA-1 OF ALABAMA

RSA-1 Deferred Compensation Plan Enrollment

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Your Information

Name ____
First Middle/Maiden Last

Address ____
Street or P.O. Box City State ZIP Code

Telephone Number ____________________ Email Address ____________________

Date of Birth ____________________ Sex ❑ Male ❑ Female

Employer Information

Employer ____
Agency Name

Address ____
Street or P.O. Box City State ZIP Code

Telephone Number ____________________ Email Address ____________________

My current status is:

❑ Employees' Retirement System (ERS) member
❑ Teachers' Retirement System (TRS) member
❑ Judicial Retirement Fund (JRF) member
❑ I am not a member of ERS, TRS, or JRF

Signature Certification

Please read carefully as the following statements will apply to your RSA-1 account:

I have designated my beneficiaries on the separate Beneficiary Designation form (return to RSA-1).

I have completed an Investment Option Election form (return to RSA-1).

I will complete an Authorization to Defer Compensation form and deliver it to **my payroll officer** to begin deferrals. **It takes at least two weeks** to process the RSA-1 Enrollment, Beneficiary Designation, and Investment Option Election forms.

I understand that I may not withdraw this account unless I meet one of the following conditions:

1. Separation from service through retirement or termination from employment
2. The attainment of age 70 ½
3. Unforeseeable emergency (must be approved by Plan Administrator)
4. Small Balance Distribution

Your signature affirms your understanding of each of these statements and is your agreement to be bound by the terms and conditions set forth in the amended and restated RSA-1 Plan Document, which is located on the RSA website.

Sign Here ➔ **Your Signature** ______________________________ **Date** ____________

RSA-1 and PEIRAF Beneficiary Designation

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Type of Account: ❑ PEIRAF ❑ RSA-1

Your Information

Please note: Divorce or annulment of a marriage shall not revoke or void the designation of a spouse as beneficiary for any benefits payable by RSA.

Name ______________________________
First Middle/Maiden Last

Address ______________________________
Street or P.O. Box City State ZIP Code

Telephone Number ______________ Email Address ______________

Date of Birth ______________ Sex ❑ Male ❑ Female

Designation of Primary Beneficiary(ies)

I hereby designate the following person(s) as my **PRIMARY BENEFICIARY(IES)** to receive any benefit that may become due at or after my death according to the terms of the Plan.

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ❑ Male ❑ Female

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ❑ Male ❑ Female

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ❑ Male ❑ Female

Name ______________ Relationship ______________ Date of Birth ______________

Address ______________________________
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ❑ Male ❑ Female

❑ Check if contingent beneficiary information is continued on the back of this form.

Signature Certification

Sign Here

Please have your signature acknowledged before a Notary Public.

Your Signature ______________________________ **Date** ______________

Seal

State of ______________, County of ______________

On this ______ day of ______________, 20 ______, personally appeared before me, the above named individual and acknowledged under oath that the statements made are true.

Signature of Notary Public ______________________________

My Commission Expires ______________________________

If completing this side of the form, do not forget to sign at the bottom.

Name ______________________ **SSN** ___ ___ ___ ___ ___ ___ ___ ___ ___

Designation of Contingent Beneficiary(ies)

In the event the primary beneficiary(ies) designated above does **not** survive me, I hereby designate the following person(s) as my **CONTINGENT BENEFICIARY(IES)** to receive any benefit that may become due at or after my death according to the terms of the Plan.

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ☐ Male ☐ Female

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ☐ Male ☐ Female

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ☐ Male ☐ Female

Name ______________________ Relationship ____________ Date of Birth ____________

Address ____
Street or P.O. Box City State ZIP Code

SSN ______________ Telephone ______________ Sex ☐ Male ☐ Female

Sign Here ➔ **Your Signature** ______________________ **Date** ____________

**Page two must be signed if any contingent beneficiary information is submitted on this side of the form.*

RSA-1 OF ALABAMA

RSA-1 Investment Option Election for New Accounts

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___   ___ ___   ___ ___ ___ ___

Your Information

Name ____
First   Middle/Maiden   Last

Address ____
Street or P.O. Box   City   State   ZIP Code

Telephone Number ____________________ Email Address ____________________

Date of Birth ____________________ PID (optional) ____________________

RSA-1 Accounts Only

I elect the following investment option for future deferrals. You can elect to have 100% in the fixed income, equity, or short-term investment option election or split the percentages between the investment options, but they must add up to 100%.

Invest ______________ % of **new deferrals** in the RSA-1 **FIXED INCOME** investment option.

Invest ______________ % of **new deferrals** in the RSA-1 **EQUITY** investment option.

Invest ______________ % of **new deferrals** in the RSA-1 **SHORT-TERM** investment option.

DROP, PLOP, ERIP, TSP Rollover Accounts Only

I elect the following investment option for:
Check one: ❑ **DROP** ❑ **PLOP** ❑ **ERIP** ❑ **TSP**

You can elect to have 100% in the fixed income, equity, or short-term investment option election or split the percentages between the investment options, but they must add up to 100%.

Invest ______________ % of **funds** in the RSA-1 **FIXED INCOME** investment option.

Invest ______________ % of **funds** in the RSA-1 **EQUITY** investment option.

Invest ______________ % of **funds** in the RSA-1 **SHORT-TERM** investment option.

RSA-1 **FIXED INCOME** investment option: The fixed income portfolio is invested in various debt instruments with maturities greater than one year, such as corporate bonds, U.S. agency obligations, mortgage obligations, and commercial paper.

RSA-1 **EQUITY** investment option: The equity portfolio is invested in a S&P 500 Index Fund.

RSA-1 **SHORT-TERM** investment option: The short-term investment fund (STIF) could include high-quality money market securities, U.S. Treasury bills or notes, and U.S. Government agency notes with a maturity of one year or less.

Please note that Fixed Income, Equity, and Short-Term Investment Options are all subject to market fluctuations.

Signature Certification

I understand the following regarding this investment option election:

My election must be made prior to the funds being submitted or transferred.
My election can be made **once every 90 days**.
My election will remain in effect until a subsequent election is made, but it must remain in effect for **90 days**.

Sign Here ➔ **Your Signature** ______________________________ **Date** ______________

RSA-1 Authorization to Defer Compensation

RSA-1 OF ALABAMA
Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___ ___ ___ ___ ___ ___ ___ ___ ___

Use this form to begin, restart, increase/decrease, or stop deferral amounts.

Your Information

Complete and submit to your Payroll Officer to begin deferrals.

Do not submit this form to RSA-1 or the Retirement Systems of Alabama.

Name ____
First Middle/Maiden Last

Address ____
Street or P.O. Box City State ZIP Code

Telephone Number ____________________ Email Address ____________________

Date of Birth ____________________ Sex ❑ Male ❑ Female

Deferral Information

Specify one of the following:

❑ New Enrollment ❑ Restart ❑ Sick/Annual Leave
❑ Increase Deferrals ❑ Decrease Deferrals ❑ Stop Deferrals

If enrolling in RSA-1, please make certain that your RSA-1 Enrollment, Beneficiary Designation, and Investment Option Election forms have been submitted to the RSA-1 Deferred Compensation Plan **before** submitting this form to your Payroll Officer. **Note the following exception:** If stopping deferrals due to **financial hardship**, your Payroll Officer must sign verifying that deferrals have been stopped. A copy of this form must then be submitted to RSA-1 with your Financial Hardship Distribution Request.

1. **Please defer** $ ____________________ **per pay period** from my salary and remit this amount to the RSA-1 Deferred Compensation Plan. **If stopping deferrals, enter zero (0) for the dollar amount.**

2. **Effective date*** ____________________ Effective date may not be earlier than the first of the month following the date this form is submitted to the payroll office.

3. If you are deferring payments for **Sick or Annual Leave** (must be enrolled), please indicate the amounts below:

   Please defer $ ____________________ of my payment for unused Sick Leave to RSA-1.

   Please defer $ ____________________ of my payment for unused Annual Leave to RSA-1.

Signature of Employee

Sign Here

Your Signature ______________________________ **Date** ____________

Payroll Officer Information

Only if submitting a Financial Hardship Distribution Request or a Distribution Request.

Payroll Officer Signature ______________________________ **Date** ____________

Name and Title ______________________________
Please Print

Payroll Officer Telephone ____________________ Email Address ____________________

Date Deferrals Stopped ____________________

***Please submit all required enrollment forms to RSA-1. Contributions received by RSA-1 without executed enrollment forms will be refunded.**

OF ALABAMA

RSA-1 Deferred Compensation Plan Enrollment

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130-2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN ___

Your Information

Name ___
First Middle/Maiden Last

Address ___
Street or P.O Box City State ZIP Code

Telephone Number ___ Email Address ___

Date of Birth ___ Sex ☐ Male ☐ Female

Employer Information

Employer ___
Agency Name

Address ___
Street or P.O. Box City State ZIP Code

Telephone Number ___ Email Address ___

My current status is:

☐ Employees' Retirement System (ERS) member
☐ Teachers' Retirement System (TRS) member
☐ Judicial Retirement Fund (JRF) member
☐ I am not a member of ERS, TRS, or JRF

Signature Certification

Please read carefully as the following statements will apply to your RSA-1 account:

I have designated my beneficiaries on the separate Beneficiary Designation form (return to RSA-1).

I have completed an Investment Option Election form (return to RSA-1).

I will complete an Authorization to Defer Compensation form and deliver it to **my payroll officer** to begin deferrals. **It takes at least two weeks** to process the RSA-1 Enrollment, Beneficiary Designation, and Investment Option Election forms.

I understand that I may not withdraw this account unless I meet one of the following conditions:

1. Separation from service through retirement or termination from employment
2. The attainment of age 72
3. Unforeseeable emergency (must be approved by Plan Administrator)
4. Small Balance Distribution

Your signature affirms your understanding of each of these statements and is your agreement to be bound by the terms and conditions set forth in the amended and restated RSA-1 Plan Document, which is located on the RSA website.

Sign Here → **Your Signature** ___ **Date** ___

RSA-1 OF ALABAMA

RSA-1 Investment Option Election for New Accounts

Retirement Systems of Alabama
PO Box 302150, Montgomery, Alabama 36130 2150
877.517.0020 • 334.517.7000 • www.rsa-al.gov

Your SSN

Check all that apply: ☐ RSA-1 ☐ DROP ☐ PLOP ☐ ERIP

Your Information

Name ______________________________
First Middle/Maiden Last

Address ______________________________
Street or P.O. Box City State ZIP Code

Telephone Number ____________________ Email Address ____________________

Date of Birth ____________________ PID (optional) ____________________

RSA-1 Accounts Only

I elect the following investment option for future deferrals. You can elect to have 100% in the bond, stock, or short-term investment option election or split the percentages between the investment options, but they must add up to 100%.

Invest ____________ % of **new deferrals** in the RSA-1 **BOND** investment option. The bond portfolio is invested in various debt instruments with maturities greater than one year such as corporate bonds, U.S. agency obligations, mortgage obligations, and commercial paper.

Invest ____________ % of **new deferrals** in the RSA-1 **STOCK** investment option. The stock portfolio is invested in an S&P 500 Index Fund.

Invest ____________ % of **new deferrals** in the RSA-1 **SHORT-TERM** investment option. The short-term investment fund (STIF) could include high-quality money market securities, U.S. Treasury bills or notes, and U.S. government agency notes with a maturity of one year or less.

DROP/PLOP/ERIP Rollover Accounts Only

I elect the following investment option for:
Check one: ☐ DROP ☐ PLOP ☐ ERIP

You can elect to have 100% in the bond, stock, or short-term investment option election or split the percentages between the investment options, but they must add up to 100%.

Invest ____________ % of **funds** in the RSA-1 **BOND** investment option. The bond portfolio is invested in various debt instruments with maturities greater than one year such as corporate bonds, U.S. agency obligations, mortgage obligations, and commercial paper.

Invest ____________ % of **funds** in the RSA-1 **STOCK** investment option. The stock portfolio is invested in an S&P 500 Index Fund.

Invest ____________ % of **funds** in the RSA-1 **SHORT-TERM** investment option. The short-term investment fund (STIF) could include high-quality money market securities, U.S. Treasury bills or notes, and U.S. government agency notes with a maturity of one year or less.

Signature Certification

I understand the following regarding this investment option election:

My election must be made prior to the funds being submitted or transferred. My election can be made once every **90 days**.
My election will remain in effect until a subsequent election is made, but it must remain in effect for **90 days**.

Sign Here ➔ **Your Signature** ______________________________ **Date** ____________

Authorization for Direct Deposit-Employee Form

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

Account Type (check only one) _____ Checking ______ Savings

Employee's Bank Name ____

Bank Routing Number (ABA) ____________________ Account Number ____________________

ATTACH A VOIDED CHECK FOR ACCOUNT HERE

This authorization will be in effect until the County receives a written termination request and/or change of account information. This must be received by Payroll within two weeks of the upcoming pay date.

Signature ____ **Date** _____________

Printed Name ______________________________________**Department** _______________

Date Received (PR) _______________ **Processed by** _________________________________

This document must be signed by employee requesting automatic deposit of paychecks and retained on file by the employer as a permanent record.

Walker County Commission

Benefit Sign Up Summary-Date of Hire

______Enroll _____Decline Southland Dental Insurance
(*Open enrollment)

_____Enroll ______Decline Southland Vision Insurance
(*Open enrollment)

______Enroll ______Decline Blue Cross Blue Shield Dental
(* No open enrollment)

______Enroll ______Decline VSP- Vision Insurance

(*open enrollment)

_____ Enroll _____Decline RSA-1
(Can enroll at anytime)

PRINT NAME ________________________________

SIGNATURE__________________________________

DATE __________________________________

*OPEN ENROLLMENT IN THE MONTH OF NOVEMBER EACH YEAR