



STUDENT EMPLOYMENT

NEW HIRE PACKET

Please complete in ink

- 1. Complete the top portion of the first page in this packet.**
- 2. Take this entire packet to the department you are applying for work.**
- 3. Once hired, complete the rest of the packet and return to the Supervisor hiring you.**



GENEVA COLLEGE

STUDENT EMPLOYMENT APPLICATION

Applicant Information

SEMESTER: FALL SPRING SUMMER CALENDAR YEAR: _____
PLEASE PRINT

Department in which you are applying: _____ Position applying for: _____

Applicant Name: _____ Date: _____
Last First M.I.

Home Address: _____
Street City State Zip Code

Cell Phone: _____ Home Phone: _____ Email Address: _____

Are you 18 years of age or older? Yes No If no, give date of birth: _____ Social Security last 4#'s: XXX-XX-_____

Do you currently attend Geneva College? Yes No Geneva Student I.D. #: _____ Geneva Box #: _____

Enrollment Status: Full-Time Part-Time Number of Credits anticipated during term of employment for which you are applying _____

Fall Class Status: Fr So Jr Sr Grad Major: _____

Have you been granted Work-Study Funds in your Financial Aid Award Letter? Yes No Don't Know

Are you authorized to work in the U.S.? Yes No If no, will you require sponsorship? Yes No

Have you completed a New Hire Packet or received a paycheck for work from Geneva in the past? Yes No
If yes, which department and when? _____

Earliest Date you can begin working? _____ Are you able to work the entire semester? Yes No

Please list any unique/specific skills and/or experience you possess that you think the department you are applying for could utilize.

Have you ever been convicted or plead guilty to a felony or misdemeanor or admitted to facts during a legal proceeding that constitute a felony or misdemeanor, even as a minor? (Do not include minor traffic violations.) Include any Accelerated Rehabilitative Disposition (ARD) or alternative criminal charge resolution processes. Yes No

If yes, list the date of the conviction(s), the name/location of the court in which convicted, and a description of the nature of the crime. Attach additional pages if necessary.

I hereby affirm that the information given by me on this application for employment is complete and accurate. I understand that any falsification or omission of information will be grounds for immediate dismissal. I further authorize the College to investigate and/or verify any information on this application or other supporting documents.

Applicant Signature _____ Date _____

TO BE COMPLETED BY HIRING SUPERVISOR

PLEASE PRINT

Starting Date: _____

Supervisor: _____ Department: _____ Account #: _____

Wage Rate (Check One): \$7.25- Minimum Wage Other: \$ _____

(Please explain rationale if wage rate is other than minimum wage)

Duties: _____

Supervisor's Signature: _____



Check this box if your student will have direct contact with minors in their work other than prospective or matriculated students at Geneva College. This will require PA Act 153 Clearances that must be complete and on file in HR before work can begin.

Human Resources Approval _____

Date: _____

Payroll: _____

INSTRUCTIONS FOR COMPLETING YOUR FORM W-4

To complete the Form W-4 you only need to fill out the bottom portion of the page, numbers 1-5, and sign at the bottom.

1. Print you first name, middle initial and last name.
Write in your home address including number and street name.
2. Fill in your Social Security number.
3. Check the appropriate boxes.
4. If your last name is different than the name on your Social Security Card, check the box.
5. Write in the total number of allowances that you are claiming.

****Read and understand the statement****

****Be sure to sign the document****

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds \$1,050 and includes more than \$350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than \$1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed \$130,000 (Single) or \$180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A _____
B	Enter "1" if: { • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are \$1,500 or less. }	B _____
C	Enter "1" for your spouse. But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C _____
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D _____
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E _____
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F _____
G	Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than \$70,000 (\$100,000 if married), enter "2" for each eligible child; then less "1" if you have two to four eligible children or less "2" if you have five or more eligible children. • If your total income will be between \$70,000 and \$84,000 (\$100,000 and \$119,000 if married), enter "1" for each eligible child.	G _____
H	Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.) ▶	H _____
	For accuracy, complete all worksheets that apply. { • If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2. • If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed \$50,000 (\$20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 • If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.	

----- Separate here and give Form W-4 to your employer. Keep the top part for your records. -----

Form W-4 Department of the Treasury Internal Revenue Service	Employee's Withholding Allowance Certificate	OMB No. 1545-0074 2017
▶ Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.		

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code		4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ <input type="checkbox"/>
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 _____
6 Additional amount, if any, you want withheld from each paycheck		6 \$ _____
7 I claim exemption from withholding for 2017, and I certify that I meet both of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶		7 _____

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

Employee's signature (This form is not valid unless you sign it.) ▶		Date ▶
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)
Geneva College, 3200 College Avenue, Beaver Falls, PA 15010		25-0965376

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over \$313,800 and you're married filing jointly or you're a qualifying widow(er); \$287,650 if you're head of household; \$261,500 if you're single, not head of household and not a qualifying widow(er); or \$156,900 if you're married filing separately. See Pub. 505 for details	1	\$ _____
2	Enter: $\left\{ \begin{array}{l} \$12,700 \text{ if married filing jointly or qualifying widow(er)} \\ \$9,350 \text{ if head of household} \\ \$6,350 \text{ if single or married filing separately} \end{array} \right\}$	2	\$ _____
3	Subtract line 2 from line 1. If zero or less, enter "-0-"	3	\$ _____
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	\$ _____
5	Add lines 3 and 4 and enter the total. (Include any amount for credits from the <i>Converting Credits to Withholding Allowances for 2017 Form W-4</i> worksheet in Pub. 505.)	5	\$ _____
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	\$ _____
7	Subtract line 6 from line 5. If zero or less, enter "-0-"	7	\$ _____
8	Divide the amount on line 7 by \$4,050 and enter the result here. Drop any fraction	8	_____
9	Enter the number from the Personal Allowances Worksheet , line H, page 1	9	_____
10	Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet , also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1	10	_____

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet)	1	_____
2	Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However , if you are married filing jointly and wages from the highest paying job are \$65,000 or less, do not enter more than "3"	2	_____
3	If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. Do not use the rest of this worksheet	3	_____

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	_____
5	Enter the number from line 1 of this worksheet	5	_____
6	Subtract line 5 from line 4	6	_____
7	Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here	7	\$ _____
8	Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	\$ _____
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	\$ _____

Table 1

Table 2

Married Filing Jointly		All Others		Married Filing Jointly		All Others	
If wages from LOWEST paying job are—	Enter on line 2 above	If wages from LOWEST paying job are—	Enter on line 2 above	If wages from HIGHEST paying job are—	Enter on line 7 above	If wages from HIGHEST paying job are—	Enter on line 7 above
\$0 - \$7,000	0	\$0 - \$8,000	0	\$0 - \$75,000	\$610	\$0 - \$38,000	\$610
7,001 - 14,000	1	8,001 - 16,000	1	75,001 - 135,000	1,010	38,001 - 85,000	1,010
14,001 - 22,000	2	16,001 - 26,000	2	135,001 - 205,000	1,130	85,001 - 185,000	1,130
22,001 - 27,000	3	26,001 - 34,000	3	205,001 - 360,000	1,340	185,001 - 400,000	1,340
27,001 - 35,000	4	34,001 - 44,000	4	360,001 - 405,000	1,420	400,001 and over	1,600
35,001 - 44,000	5	44,001 - 70,000	5	405,001 and over	1,600		
44,001 - 55,000	6	70,001 - 85,000	6				
55,001 - 65,000	7	85,001 - 110,000	7				
65,001 - 75,000	8	110,001 - 125,000	8				
75,001 - 80,000	9	125,001 - 140,000	9				
80,001 - 95,000	10	140,001 and over	10				
95,001 - 115,000	11						
115,001 - 130,000	12						
130,001 - 140,000	13						
140,001 - 150,000	14						
150,001 and over	15						

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

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

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

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

HOW TO FILL OUT YOUR I-9 FORM
(Department of Homeland Security)

1. Complete Section 1 of this form.
2. You will also need to bring two original forms of eligible I.D. to the hiring supervisor or Human Resources. Acceptable forms of I.D.'s are listed on the third page of this form. An example would be a driver's license and social security card.
3. Your paperwork cannot be processed and you cannot begin work until the supervisor or Human Resources are shown the original documents needed.



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

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

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

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

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)
Address (Street Number and Name)			Apt. Number	City or Town	State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number □□□□ - □□ - □□□□	Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





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

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

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

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)		Expiration Date (if any)(mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write in This Space
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any)(mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

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

Signature of Employer or Authorized Representative		Today's Date(mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative	Employer's Business or Organization Name Geneva College	
Employer's Business or Organization Address (Street Number and Name) 3200 College Avenue		City or Town Beaver Falls	State PA	ZIP Code 15010

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

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

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

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	LIST B Documents that Establish Identity	LIST C Documents that Establish Employment Authorization
OR	AND	
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 	<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of Birth Abroad issued by the Department of State (Form FS-545) 3. Certification of Report of Birth issued by the Department of State (Form DS-1350) 4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 5. Native American tribal document 6. U.S. Citizen ID Card (Form I-197) 7. Identification Card for Use of Resident Citizen in the United States (Form I-179) 8. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

**SIGN AND READ
THE
FOLLOWING THREE PAGES**

- 1. Worker's Compensation Notification
Read and sign both forms informing you of what to do if you are injured while working. Keep the panel physician list for your file.**
- 2. Substance Abuse Policy
Please read and sign this form.**
- 3. Student Confidentiality Agreement
Please read and sign this form.**



EMPLOYEE’S RIGHTS & DUTIES UNDER SECTION 306 (f.1) OF THE PENNSYLVANIA WORKERS’ COMPENSATION ACT

If you are injured while at work and medical treatment is necessary, you are required to visit one of the physicians or health care providers on the list designated by your employer for a period of 90 days from your first visit with the physician or health care provider.

All reasonable medical treatment and supplies (e.g. medicines, prosthetics) related to the injury will be paid for by the employer provided treatment is by a designated physician or health care provider on the list during the 90-day period. Charges for treatment and supplies are specified by the ACT. You are not responsible for the payment of any charges in excess of those specified by the ACT.

During the 90-day period, you may change from one designated physician or health care provider on the list to another physician or health care provider on the list, and the treatment will be paid for by the employer.

If the designated physician or health care provider refers you to a non-designated provider, the employer will pay for the treatment by the non-designated provider.

You have the right to obtain emergency medical treatment from a non-designated physician or health care provider however, the subsequent non-emergency treatment must be by a designated physician or health care provider for the remainder of the 90-day period.

You may seek treatment or consultation from a non-designated physician or health care provider during the 90-day period however, you are responsible for the charges for this treatment during the 90-day period.

If the employer designated physician or health care provider recommends invasive surgery, you are permitted to obtain a second opinion from a non-designated physician or health care provider. Your employer will pay for the cost for this opinion. If this opinion differs from the opinion of the designated physician or health care provider and provides a specific and detailed course of treatment, you may elect to undergo this treatment. The treatment however must be provided by a designated physician or health care provider for 90 days from the date of the visit to the non-designated physician.

You have the right to seek treatment from any physician or health care provider after the 90-day period has ended, and your employer will pay for this treatment provided it is reasonable and necessary.

You have the duty to notify your employer of treatment by a non-designated physician or health care provider within five days of your first visit to this physician or provider. Your employer may not be required to pay for treatment by a non-designated physician or health care provider prior to notification. The employer however shall pay for this treatment once notified unless the treatment is found to be unreasonable.

Signing this form is an acknowledgment of your rights and duties. You may not refuse to sign this acknowledgment in order to avoid your duties.

If you have any questions, please feel free to contact the Bureau of Workers’ Compensation at 1-800-482-2383 or 1-717-783-5421.

I ACKNOWLEDGE THAT I HAVE BEEN INFORMED OF AN UNDERSTAND THE ABOVE RIGHTS AND DUTIES.		
_____	_____	_____
Employee Name	Employee Signature	Date
_____	_____	_____
Supervisor Name	Supervisor Signature	Date
IF THE EMPLOYEE IS UNABLE OR REFUSED TO SIGN, IT IS ACKNOWLEDGED THAT THE EMPLOYEE WAS PROVIDED A COPY OF THIS DOCUMENT.		
_____	_____	_____
Supervisor Name	Supervisor Signature	Date



NOTICE: MEDICAL TREATMENT FOR YOUR WORK INJURY OR OCCUPATIONAL ILLNESS

Your employer has selected a list of 6 or more physicians and other health care providers who are available to treat your work-related injuries and illnesses during the first 90 days of treatment. This list is posted at _____ for you to view. Also, you may get a copy of this list from _____.

If you are injured at work or suffer an occupational illness, you have certain legal RIGHTS and DUTIES under Section 306(f.1)(1)(i) of the Workers' Compensation Act regarding your medical treatment. These rights and duties are summarized below.

MEDICAL TREATMENT: DURING THE FIRST 90 DAYS

- You have the RIGHT to receive reasonable and necessary medical treatment for your work injury or occupational illness. Your employer must pay for the treatment, as long as the treatment is by one of the listed providers.
- You have the RIGHT to choose which of the listed providers will treat you for your work injury or illness.
- You have the RIGHT to switch among any of the listed providers when you receive treatment; and if a listed provider refers you to a provider not on your employer's list, you have the RIGHT to receive treatment from the referral provider.
- You have the RIGHT to receive emergency medical treatment from any provider. However, non-emergency treatment must be given by a listed provider.
- If a listed provider prescribes surgery for you, you have the RIGHT to receive a second opinion from any provider of your choice. If that opinion is different from the opinion of the listed provider, you have the RIGHT to choose which course of treatment to follow. If you choose the treatment prescribed in the second opinion, you must receive the treatment from a listed provider for a period of 90 days after the date of your visit to the provider of the second opinion.
- You have the DUTY to visit one or more of the listed providers for the first 90 days of treatment for your work injury or illness if you expect your employer to pay for the medical treatment you receive.
- If you seek treatment for your work injury or illness from a provider who is not on the list, your employer may not have to pay for this medical treatment during this 90-day period. Therefore, you should talk to your employer before seeking treatment from a provider who is not on the list.

IMPORTANT: The requirements your employer must meet to have a valid list of at least 6 providers are shown on the reverse side of this form. If the list does not meet these requirements, it is not a valid list, and you have the right to seek medical treatment for your work injury or occupational illness from any health care provider of your choice.

MEDICAL TREATMENT: AFTER THE FIRST 90 DAYS

- You have the RIGHT to receive treatment from any physician or other health care provider of your choice, whether or not they are listed by your employer. Your employer must pay for this treatment, as long as it is reasonable and necessary for your work injury or occupational illness and has been properly documented by the physician or other health care provider.
- You have the DUTY to notify your employer if you receive treatment from a physician or other health care provider who is not listed by your employer. You must notify your employer within five days of the first visit to any provider who is not on your employer's list. The employer may not be required to pay for treatment received until you have given this notice.

Your signature on this form indicates that you have been informed of and you understand these rights and duties. If you have questions, be sure you have your rights and duties explained to you before signing this form.

I HAVE BEEN INFORMED OF MY MEDICAL TREATMENT RIGHTS AND DUTIES WITH REGARD TO WORK-RELATED INJURIES AND OCCUPATIONAL ILLNESSES. THIS NOTICE WAS PRESENTED TO ME AT (check one):

- TIME OF HIRE WHEN I WAS INJURED OTHER

EMPLOYEE: _____ DATE: _____

EMPLOYER REPRESENTATIVE: _____ DATE: _____

(OVER)



REQUIREMENTS FOR EMPLOYER'S LIST OF HEALTH CARE PROVIDERS

1. There must be at least 6 health care providers on the list, but there may be more than 6 listed.
2. At least 3 of the health care providers on the list must be physicians.
3. No more than 4 of the health care providers on the list may be coordinated care organizations (CCOs).
4. The names, addresses, phone numbers and areas of medical specialties of all health care providers must be included on the list.
5. The health care providers on the list must be geographically accessible and must have specialties that are appropriate based on the anticipated work-related medical problems of the employees.
6. Your employer must specify on the list if any of the health care providers on the list are employed, owned or controlled by your employer or its workers' compensation insurance company.

NOTE: Your employer's list of health care providers must meet all of the above requirements. If the list does not meet all of these requirements, you do not have to choose a provider from the list. Instead, you have the right to seek medical treatment with any health care provider of your choice.

BUREAU OF WORKERS' COMPENSATION
HELPLINE INFORMATION CENTER
1-800-482-2383 (long-distance calls inside PA)
1-717-772-4447 (local and calls outside PA)



Geneva College - Beaver Falls 15010

Your Workers' Compensation Insurance Carrier is:

BrickStreet Insurance

PO Box 3151 Charleston, WV 25332

Phone: 1-866-452-7425

NOTICE TO EMPLOYEES IN CASE OF WORK-RELATED INJURIES

1. If you suffer a work-related injury, your employer or its insurance company must pay for reasonable surgical and medical services and supplies, orthopedic appliances and prosthesis, including training in their use.
2. In order to insure that your medical treatment will be paid for by your employer or the insurance company, you must select from one of the following health care providers. You must continue to visit one of the providers listed below, if you need treatment, for ninety (90) days from the date of your first visit.
3. If one of the providers below refers you to another licensed specialist, your employer or their insurer will pay the bill for these services.
4. After this ninety- (90) day period, if you still need treatment and your employer has provided a list as set forth above, you may choose to go to another health care provider for treatment. You should notify your employer of this action within five days of your visit to said provider.
5. If a physician on the list prescribes invasive surgery, you may obtain a second opinion from any physician of your choice. If the second opinion is different than the listed physician's opinion, you may determine which course of treatment to follow; however, the second opinion must contain a specific and detailed treatment plan. If you choose the second opinion, the procedures in that opinion must be performed by one of the physicians on the list for the first ninety- (90) days. Therefore, in this situation, the employee may be required to treat with an employer designated provider for up to 180 days.
6. If you are faced with a medical emergency, you may secure assistance from a hospital, physician, or health care provider of your choice for your work related injury. However, when the emergency is resolved, you must seek treatment from a provider listed below.

<u>Name</u>	<u>Address</u>	<u>Phone</u>	<u>Area of Specialty</u>
MedExpress (Multiple Locations)	2652 Darlington Road, Suite 10 Beaver Falls, PA 15010	724-891-3278	Occupational Medicine / Urgent Care
MedExpress (Multiple Locations)	3944 Brodhead Road, Suite 7B Monaca, PA 15061	724-773-0777	Occupational Medicine / Urgent Care
Heritage Valley Signature BusinessCare	5000 Industrial Blvd. Aliquippa, PA 15001	724-773-6464	Occupational Medicine
Internal Medicine Specialist (SVMG)	2360 Hospital Drive Aliquippa, PA 15001	724-378-0830	Occupational Medicine
Rehabilitation and Pain Specialists (Multiple Locations)	301 Ohio River Blvd., Suite 203 Sewickley, PA 15143	412-963-6480	Physiatry
Association of Specialty Physicians Inc. - Orthopedic (Multiple Locations)	Beaver Medical Commons, 1030 Beaver Hollow Road Beaver, PA 15009	724-775-4242	Orthopedics
Greater Pittsburgh Orthopedic Associates (Multiple Locations)	Brush Creek Commons 144 Emeryville Drive, Suite 130 Cranberry Township, PA 16066	800-284-8893	Orthopedics
Greater Pittsburgh Orthopedic Associates (Multiple Locations)	1099 Ohio River Blvd. Sewickley, PA 15143	412-741-9226	Orthopedics
Greater Pittsburgh Orthopedic Associates (Multiple Locations)	725 Cherrington Parkway, Suite 200 Moon Township, PA 15108	412-262-7800	Orthopedics
Tri-State Orthopaedics & Sports Medicine, Inc. (Multiple Locations)	Park Place at Chapel Harbor 300 Chapel Harbor Drive, Suite 300 Pittsburgh, PA 15238	412-696-0300	Orthopedics
Heritage Valley Surgical Services	93 Boundry Lane Bridgewater, PA 15009	724-728-8300	General Surgery
Allegheny Neurology Associates	1200 Sharon Road, Suite 201 Beaver, PA 15009	724-774-0398	Neurology
Zorub & Weinberger, MD	5200 Centre Avenue, Suite 617 Pittsburgh, PA 15232	412-623-2972	Neurosurgery
Allegheny Health Network Department of Neurosurgery (Multiple Locations)	One Beaver Place, 701 Fifth Street, 2nd Floor Beaver, PA 15009	412-359-6200	Neurosurgery
Allegheny Health Network Department of Neurosurgery (Multiple Locations)	Allegheny General Hospital 320 East North Avenue, Suite 208 Pittsburgh, PA 15212	412-359-6200	Neurosurgery
Allegheny Health Network Department of Neurosurgery (Multiple Locations)	4815 Liberty Avenue, 448 Mellon Pavilion Pittsburgh, PA 15224	412-682-6800	Neurosurgery

Daniel J. Nadler & Associates (Multiple Locations)	1200 Sharon Road, Suite 202 Beaver, PA 15009	724-774-5920	Ophthalmology
John T. Gump, DC	1012 Eighth Avenue Beaver Falls, PA 15010	724-846-7489	Chiropractic
Joseph Kelly, DC	72474425 Dutch Ridge Road Beaver, PA 15009	724-495-3313	Chiropractic
Haczela Chiropractic Center	111 Wagner Road Monaca, PA 15061	724-775-1214	Chiropractic
College Hill Podiatry	6832 Big Beaver Blvd. Beaver Falls, PA 15010	724-843-7010	Podiatry

CONVENIENT NETWORK LOCATIONS LISTED BELOW

Premier Comp PT Network	Call Toll Free for Closest Location	1-888-594-4001	Physical Therapy
Premier Comp MRI Network	Call Toll Free for Closest Location	1-888-594-4001	MRIs
Coventry DME Plus	Call Toll Free	1-877-203-9899	DME
Optum Pharmacy Network	Call Toll Free for Closest Location or go to www.cypresscare.com	1-800-419-7191	Pharmacy

Panel Date: 2/1/2017



SUBSTANCE ABUSE POLICY

Geneva College is committed to providing a safe work environment and to fostering the well being and health of its employees. The College's long-standing policy has been to prohibit the use of illegal drugs, alcoholic beverages, and abuse of ethical substances on College property. That commitment is jeopardized when any College employee uses drugs or alcoholic beverages on the job, comes to work under their influence, or possesses, distributes or sells illegal drugs in the workplace. Therefore, the College has established the following policy:

- It is a violation of College policy for any employee to possess, sell, trade, or offer for sale illegal drugs or alcoholic beverages on the job, or otherwise engage in the use of such substances during work hours.
- It is a violation of College policy for anyone to report to work under the influence of illegal drugs or alcoholic beverages.
- It shall be a condition of employment for employees to submit to drug testing under the following circumstances:
 - When drug screening is part of a pre-employment physical exam;
 - When there is reasonable suspicion that an employee is not fit-for-duty or is engaging in inappropriate behavior;
 - When an employee is involved in a workplace near-accident or an on-the-job accident that resulted from the employee's human error or carelessness, or when the medical attention is required for bodily injury.
- Employees must notify the College, in writing, of any conviction of a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction.
- It is a violation of College policy for anyone to use ethical drugs improperly (However, nothing in this policy precludes the appropriate use of ethical medications).
- Any employee who uses legally prescribed medications that may cause side effects must report that usage to their supervisor prior to the start of work. A determination will be made as to whether the employee can perform the essential functions of the job in a safe and appropriate manner.
- Any employee who uses an over-the-counter medication and experiences side effects while on the job, must report those side-effects to their supervisor immediately. A determination will be made as to whether the employee can continue to perform the essential functions of the job in a safe and appropriate manner.
- Violations of any part of this policy are subject to redemptive discipline up to and including termination.

As a condition of employment, I have read this policy and agree to abide by its' terms.

Name (Please Print)

Signature

Date

Student Confidentiality Agreement

In the carrying out of my duties as a student employee of Geneva College, both the College and I recognize that I will periodically be exposed to sensitive information. It is also recognized that the management of data, including personal information, grades, budgets, programs and policies is necessary to the operation of my department and of the College as a whole. I agree that all such information must be kept private and confidential for the protection of the College, protection of the persons or topics being addressed, and not least of all because Federal and/or State law protects such information.

I hereby reaffirm my personal integrity and commit myself to acting responsibly in my relations to the College. I covenant and promise that I will share with no one outside my department any personal, private or otherwise privileged information that I learn in the course of my work, except what is needed in the actual discharge of my duties. If there is doubt in my mind whether a certain matter is to be protected, I will discuss its character with my supervisor before making a disclosure. Failure to comply with this agreement may result in immediate employment termination or disciplinary action.

This responsibility to maintain confidentiality extends beyond my term of employment.

Print Name

Employee Signature

Date

DIRECT DEPOSIT FORM

You can conveniently have your paycheck directly deposited into your bank account.

You MUST attach a voided check or have a bank specification sheet from your bank attached.

Complete the following form if you wish to have direct deposit.

DIRECT DEPOSIT FORM

ID _____

NAME _____

SSN _____

Account # _____

Name(s) on the account _____

Check one:

_____ Checking Account

_____ Savings Account

Bank Name _____

Bank City, State _____

Bank Phone (_____) _____

(A copy of a voided check or a bank specification letter for this account must be attached for direct deposit.)

Signature _____ Date _____

Phone (_____) _____ or College Extension _____

.....

HUMAN RESOURCES USE ONLY

Group: DDP Priority _____ Type _____

Bank Routing # _____ Date in System _____

Apply Remainder? _____ TITLE _____

NEW HIRE REPORTING FORM

The State of Pennsylvania requires that we report all newly hired employees. The following information is required for reporting to the State.

Please complete the section that reads “Required Employee Information”. DO NOT FILL IN THE DATE OF HIRE.

New Hire Reporting Form

Required Employer Information		<i>Please mail or fax to:</i> Commonwealth of Pennsylvania New Hire Reporting Program PO Box 69400 Harrisburg, PA 17106-9400 FAX: 717-657-HIRE (717-657-4473) VOICE: 1-888-PAHIRES (1-888-724-4737) <i>(for questions only)</i> This form may be duplicated
FEIN:	2 5 0 9 6 5 3 7 6	
Employer Name:	GENEVA COLLEGE	
Address:	3200 College Avenue Beaver Falls, PA 15010-3557	
Contact Name:	Human Resources	
Contact Phone #:	(724) 847-6560	

Required Employee Information <i>(Please type or print legibly in black or blue ink.)</i>		
Employee Social Security #	Date of Birth (mm/dd/yyyy) optional	Date of Hire (mm/dd/yyyy)
First Name	Middle Name	Last Name
Address		
City	State	Zip

TAX EXEMPTION CERTIFICATE

Unless you expect to earn more than \$12,000 within Beaver Falls this year, you must complete the following form so that you are not charged the Local Services Tax.

- 1. Complete the top portion with your name, address, city/state/zip code and phone number.**
- 2. Sign and date the bottom of the back of the page.**

LOCAL SERVICES TAX – EXEMPTION CERTIFICATE

2017

Tax Year

APPLICATION FOR EXEMPTION FROM LOCAL SERVICES TAX

- A copy of this application for exemption from the Local Services Tax (LST), and all necessary supporting documents, must be completed and presented to your employer AND to the political subdivision levying the Local Services Tax for the municipality or school district in which you are primarily employed.
- This application for exemption from the Local Services Tax must be signed and dated.
- **No exemption will be approved until proper documentation has been received.**

Name: _____

Soc Sec #: _____

Address: _____

Phone #: _____

City/State: _____

Zip: _____

REASON FOR EXEMPTION

1. _____ MULTIPLE EMPLOYERS: Attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of Local Services Tax withheld. List all employers on the reverse side of this form. **You must notify your other employers of a change in principal place of employment within two weeks of the change.**
2. X EXPECTED TOTAL EARNED INCOME AND NET PROFITS FROM ALL SOURCES WITHIN Beaver Falls, PA (municipality or school district) WILL BE LESS THAN \$ \$12,000.00 : Attach copies of your last pay statements or your W-2 for the year prior.

If you are self-employed, please attach a copy of your PA Schedule C, F, or RK-1 for the prior year.
3. _____ ACTIVE DUTY MILITARY EXEMPTION: Please attach a copy of your orders directing you to active duty status. Annual training is not eligible for exemption. You are required to advise the tax office when you are discharged from active duty status.
4. _____ MILITARY DISABILITY EXEMPTION: Please attach copy of your discharge orders and a statement from the United States Veterans Administrator documenting your disability. Only 100% permanent disabilities are recognized for this exemption.

EMPLOYER: Once you receive this Exemption Certificate, you shall not withhold the Local Services Tax for the portion of the calendar year for which this certificate applies, unless you are otherwise notified or instructed by the tax collector to withhold the tax.

Tax Office: Berkheimer Tax Administrator

Phone#: (610) 588-0965

Address: P.O. Box 25156

City/State: Lehigh Valley, PA

Zip: 18002

IMPORTANT NOTE TO EMPLOYERS

1. The municipality is required by law to exempt from the LST employees whose earned income from all sources (employers and self-employment) in their municipality is less than \$12,000 when the combined rate exceeds \$10.00.
2. The school district for the municipality in which your worksite(s) is located may or may not levy an LST. If it does, the income exemption provided may differ from the municipality and can be anywhere from \$0 to \$11,999.
3. Contact the tax office where your business worksites are located to obtain this information.

HOW TO FILL OUT YOUR RESIDENCY CERTIFICATION FORM

(Local Earned Income Tax Withholding)

1. Print your name - last name, first name and middle initial.
2. Print your address - Legal home Permanent - (Street address, City, State, Zip Code, Phone #).
3. Print the City, Borough or township in which you live.
4. Print The county in which you live.
5. PSD Code and Resident EIT Rate
 - These can be looked up at www.newpa.com if you are a PA Resident.
 - If your home residence is outside of PA the code is 880000 and the rate is 0%.
 - **PLEASE COME TO THE PAYROLL OFFICE IN THE BASEMENT OF OLD MAIN IF YOU WANT HELP DETERMINING YOUR CODE AND RATE!**
6. Employer information is completed for you if you are working on campus.
7. Sign, Date and List Contact Information in the certification box at the bottom of the form.



RESIDENCY CERTIFICATION FORM

Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change.

EMPLOYEE INFORMATION - RESIDENCE LOCATION													
NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER										
			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>										
STREET ADDRESS (No PO Box, RD or RR)													
SECOND LINE OF ADDRESS													
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER										
MUNICIPALITY (City, Borough or Township)													
COUNTY	RESIDENT PSD CODE	TOTAL RESIDENT EIT RATE											
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>												

EMPLOYER INFORMATION - EMPLOYMENT LOCATION												
EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN									
Geneva College			<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> </tr> </table>	2	5	0	9	6	5	3	7	6
2	5	0	9	6	5	3	7	6				
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK (No PO Box, RD or RR)												
3200 College Avenue												
SECOND LINE OF ADDRESS												
CITY	STATE	ZIP CODE	PHONE NUMBER									
Beaver Falls	PA	15010	724-846-5100									
MUNICIPALITY (City, Borough or Township)												
Beaver Falls City												
COUNTY	WORK LOCATION PSD CODE	WORK LOCATION NON-RESIDENT EIT RATE										
Beaver	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> </tr> </table>	0	4	0	4	0	1	1.5%				
0	4	0	4	0	1							

CERTIFICATION	
Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.	
SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

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

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Geneva College		4. Employer Identification Number (EIN) 25-0965376	
5. Employer address 3200 College Avenue		6. Employer phone number 724-847-6544	
7. City Beaver Falls		8. State PA	9. ZIP code 15010
10. Who can we contact at this job? William Nichols, Payroll & Benefits Specialist			
11. Phone number (if different from above)		12. Email address wjnichol@geneva.edu	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

**CONGRATULATIONS!
YOU HAVE COMPLETED THE FORMS
REQUIRED FOR EMPLOYMENT.**

This entire packet will need to be returned to the supervisor in the department you are applying to work in.

Be sure your packet is complete and you've signed the appropriate forms.

If you have any questions or need assistance, please call Human Resources at extension 6560.