Welcome to the City of Madison!

Employee Orientation

Introduction

- Welcome
- Introductions
- Orientation Outline
  - Check it off as you go!
  - Sign and date at the end.

Mission and Vision Statements

OUR MISSION is to provide the highest quality service for the common good of our residents and visitors.

VISION

Our Madison – Inclusive, Innovative, and Thriving

OUR VALUES

Equity
We are committed to fairness, justice, and equal outcomes for all.

Civic Engagement
We believe in transparency, openness, and inclusivity. We will protect freedom of expression and engagement.

Well-Being
We are committed to creating a community where all can thrive and feel safe.

Shared Prosperity
We are dedicated to creating a community where all are able to achieve economic success and social mobility.

Stewardship
We will care for our natural, economic, fiscal, and social resources.

OUR SERVICE PROMISE

I have the highest expectations for myself and my fellow employees. Every day, I will:

- Serve coworkers and members of the public in a kind and friendly manner.
- Listen actively and communicate clearly.
- Involve those who are impacted before making decisions.
- Collaborate with others to learn, improve, and solve problems.
- Treat everyone as they would like to be treated.

WWW.CITYOFMADISON.COM/EXCELLENCE

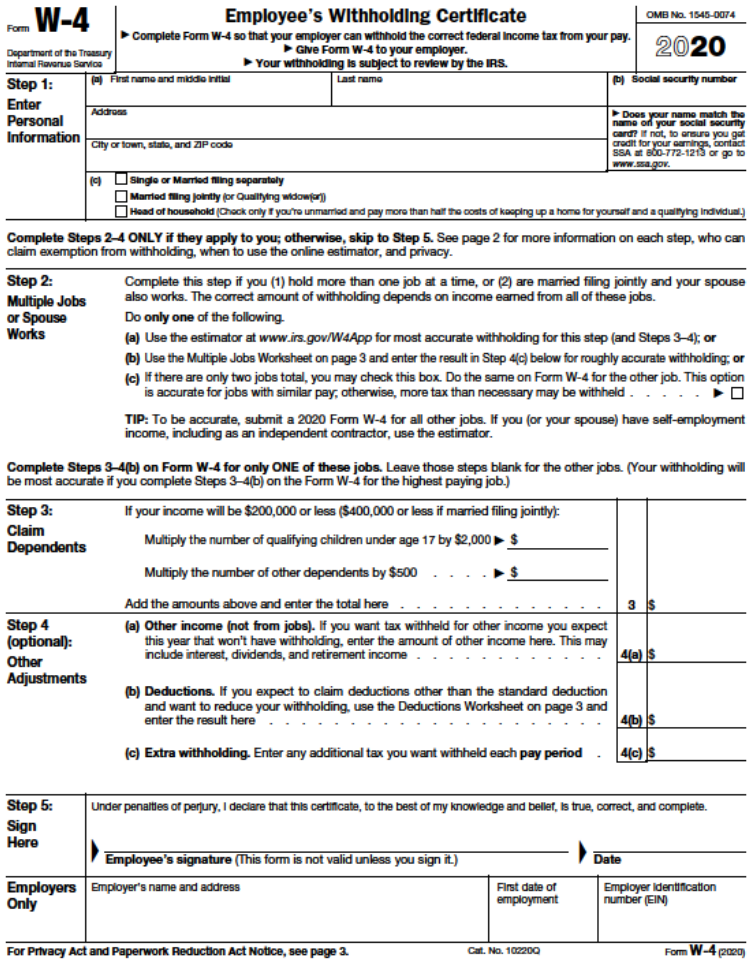
CITY OF **MADISON**

Initial Employment Forms

Initial Employment Forms

- W-4 – Federal withholding form
  - Complete applicable sections of form
  - Utilize the Multiple Jobs worksheet, as needed
  - Make sure you sign and date the document
  - You can submit a new form at any time by contacting your payroll clerk or Central Payroll

Initial Employment Forms (W-4)



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

2020

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 widow(er))
☐ **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, when to use the online estimator, 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) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

TIP: To be accurate, submit a 2020 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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 Dependents

If your 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 and 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)

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2020)

Initial Employment Forms

- W-204 - Wisconsin withholding form
  - Enter total exemptions on line 1(d)
  - Make sure you sign and date the document
  - You can submit a new form at any time by contacting your payroll clerk or Central Payroll

Initial Employment Forms (W-204)

Employee's Wisconsin Withholding Exemption Certificate/New Hire Reporting

Employee's Section

Employee's Name (last, first, middle initial	Social Security Number	Date of Birth

Employee's address (number and street)	City	State	Zip Code

☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** *If married, but legally separated, check the Single box.*

Date of Hire

FIGURE YOUR TOTAL WITHHOLDING EXEMPTIONS BELOW

Complete Lines 1 through 3 only if your Wisconsin exemptions are different than your federal allowances.

1. (a) Exemption for yourself – enter 1 .....
   (b) Exemption for your spouse – enter 1 .....
   (c) Exemption(s) for dependent(s) – you are entitled to claim an exemption for each dependent .....
   (d) Total – add lines (a) through (c) .....
2. Additional amount per pay period you want deducted (if your employer agrees) .....
3. I claim complete exemption from withholding (see instructions). Enter "Exempt" .....

I CERTIFY that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled. If claiming complete exemption from withholding, I certify that I incurred no liability for Wisconsin income tax for last year and that I anticipate that I will incur no liability for Wisconsin income tax for this year.

Signature _____ Date Signed _____ , _____

Initial Employment Forms

- I-9, Employment Eligibility Verification
  - Not necessary for current employees*
  - Complete top portion - it is not necessary to include your social security number on this page
  - Must have 1 document from list A or 1 document each from lists B and C

*A rehired employee who last worked less than two years prior to the rehire date is not required to complete a new I-9.

Initial Employment Forms (I-9)

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):

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		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. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
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		**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		8. Employment authorization document issued by the Department of Homeland Security

Initial Employment Forms

- Self Identification Form
  - Allows for reporting requirements to be met in compliance with Federal law
  - This information is used in a manner which is compliant with all State and Federal laws
  - Disclosure is voluntary

Initial Employment Forms

- Emergency Contact
  - Complete entire form
  - Provides the City with contact names in case of emergency
  - Try to ensure phone numbers included match employee work hours
  - Sign and date

Initial Employment Forms

- Declaration of Disability Form
  - Complete entire form whether declaring a disability or not
  - Information housed confidentially with Accommodations Specialist Sherry Severson
  - Helps with Affirmative Action reporting
  - Allows Accommodations Specialist to initiate discussion about reasonable accommodations

Initial Employment Forms

CITY OF MADISON
SELF-DECLARATION OF DISABILITY FORM

Last Name First Initial

Work Address Date of Hire

Department/Division _____

Work Telephone _____

Job Title _____

Work Status: _____ Permanent
_____ Hourly/Limited Term/Seasonal

NOTICE TO CITY EMPLOYEES: *Declaring a disability for employment purposes is voluntary and is only used to assist us in meeting the City's Affirmative Action efforts. Completion and return of this form is required. If no disability is declared, complete only section A below. Information provided on this form shall be maintained within the bounds of professional confidentiality. Any information provided about a disability will only be used to secure positive employment benefits and will not be released without your prior written permission. Refusal to provide the information will not subject you to any adverse treatment.*

INSTRUCTIONS: READ THE INFORMATION ON THE BACK OF THIS FORM REGARDING THE DEFINITION OF DISABILITY AND THEN COMPLETE EITHER A or B.

A. I DO NOT WISH TO DECLARE A DISABILITY

Signature Date

B. I WISH TO DECLARE A DISABILITY FOR EMPLOYMENT PURPOSES.

1. What is the nature of your condition(s)?

2. Are there any modifications in your current workplace, the equipment you use, or how your work is done that would help you do your job more efficiently and/or effectively? _____ No _____ Yes Please specify:

3. Do you wish to be contacted by the City's Occupational Accommodations Specialist?
_____ No _____ Yes *Note: All contacts can be made in a confidential manner at your home address.*

Initial Employment Forms

- Direct Deposit Authorization Form
  - May use up to 3 accounts (Madison Credit Union Accounts do not count toward limit), but must have set amounts with remainder into 1 account
  - Changes can be made at any time
  - To terminate fill out Direct Deposit Termination form
  - May not re-enroll for 6 months
  - You do not need to list previous account information
  - Fill out account information (voided check not required if you know your account and routing numbers)
  - Sign and date at the bottom

Initial Employment Forms

City of Madison
Direct Deposit Authorization Agreement

I hereby authorize the City of Madison to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my account(s) indicated below and the financial institution(s) named below to credit and debit the same entries to such account(s). If this is changing banking information, please provide the previous account information.

PREVIOUS FINANCIAL INSTITUTION 1: _____ **NEW FINANCIAL INSTITUTION 1:** _____
PREVIOUS ROUTING NUMBER 1: _____ **NEW ROUTING NUMBER 1:** _____
PREVIOUS ACCOUNT NUMBER 1: _____ **NEW ACCOUNT NUMBER 1:** _____
AMOUNT 1: Net Check **NET CHECKING:** ☐ **SAVINGS** ☐

PREVIOUS FINANCIAL INSTITUTION 2: _____ **NEW FINANCIAL INSTITUTION 2:** _____
PREVIOUS ROUTING NUMBER 2: _____ **NEW ROUTING NUMBER 2:** _____
PREVIOUS ACCOUNT NUMBER 2: _____ **NEW ACCOUNT NUMBER 2:** _____
AMOUNT 2: $ _____ **AMOUNT 2:** $ _____ **CHECKING** ☐ **SAVINGS** ☐

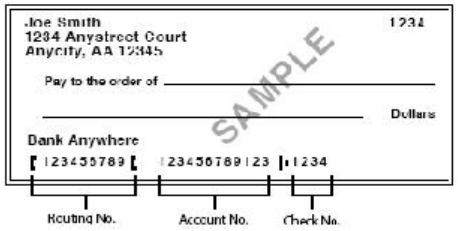
PREVIOUS FINANCIAL INSTITUTION 3: _____ **NEW FINANCIAL INSTITUTION 3:** _____
PREVIOUS ROUTING NUMBER 3: _____ **NEW ROUTING NUMBER 3:** _____
PREVIOUS ACCOUNT NUMBER 3: _____ **NEW ACCOUNT NUMBER 3:** _____
AMOUNT 3: $ _____ **AMOUNT 3:** $ _____ **CHECKING** ☐ **SAVINGS** ☐

This authority is to remain in full force and effect until the City of Madison Payroll Office has received written notification from me on its termination in such time and in such manner as to afford the City of Madison a reasonable time to act on it. I understand that, due to circumstances that are beyond the City's control, there may be instances that may delay this deposit.

MUNIS EMPLOYEE NUMBER REQUIRED: _____ **NAME:** _____
PREVIOUS EMAIL: _____ **NEW EMAIL:*** _____

SIGNATURE: _____ **DATE:** _____

*As a participant in Direct Deposit, you will no longer receive a printed check. You will receive an electronic Direct Deposit advice via the email address you provide.



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Pay
And
Leave Benefits

Getting Paid!!!

- Pay Checks
  - Issued every two weeks
  - 2 week processing time
  - Shaded dates are pay dates
  - Step increases after 6, 18, 30, 42 months
    - Salary schedules online at http://www.cityofmadison.com/finance/salarySchedule/
  - Longevity increases begin at 5th yr.
    - Longevity pay schedule in Employee Benefits Handbook

Sick Leave/Floating Holidays

- Paid Sick Leave
  - Earn 0.5 day per pay period. Accrues to 150 day limit. Balance over 150 days (or ½ of excess balance) cashes out at end of each year. See Employee Benefits Handbook for details.
  - Must be in paid status for 6 days of pay period to earn
  - For illness or injury (employee or family member). Department rules for reporting absences apply.
- Floating Holidays
  - 3.5 days per year (Teamsters receive 5 days after one year of service; none in first year)
  - Can be used during probation (unlike vacation)
  - Typically not allowed to carry over (exception if start date is on or after November 1; or per contract)
  - Some contracts may allow payout

Vacation

- Paid Vacation Leave
  - Most employees begin with 10 days per year (prorated for part-time employees)
  - Earn additional days every few years (vacation schedule in Benefits Handbook)
  - Cannot be used during first 6 months of employment
  - Department rules apply to use of leave

Holidays and Paid Leave

- Paid City Holidays
  - New Year's Day, Martin Luther King Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas
  - Some contracts have slight modifications
  - Off with pay, or 2x pay plus future day off if working
  - Sunday holidays celebrated Monday, Saturday holiday results in extra vacation day for the year (can be used after the holiday for which it is earned)
- City Paid Leave days
  - Day after Thanksgiving, Christmas Eve, and New Year's Eve, no double time paid

Insurance and Other Benefits

Returning Completed Forms

- Benefit enrollment – 30 days from date of hire
  - Health Insurance
  - Dental Insurance
  - Vision Insurance
  - Life Insurance
  - Disability (Wage) Insurance
  - Flex Spending
- All benefit forms turned in to Human Resources
- Failure to enroll may result in waiting periods and/or underwriting

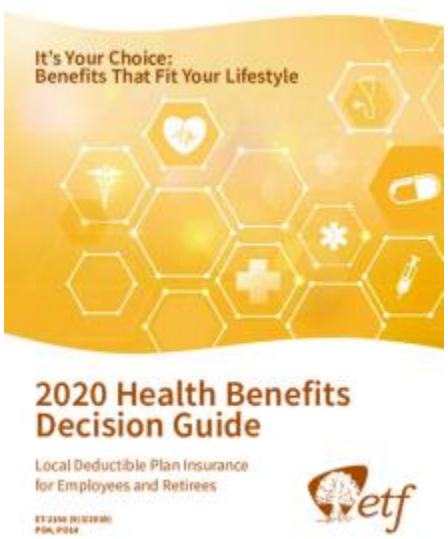
Health Insurance

- Eligibility requirements for enrollment in ETF group health with no WRS service prior to July 1, 2011
  - Permanent employee certified at 60% and higher FTE; or
  - Employee who has worked 1,200 hours in 12 months for City
- Coverage
  - If employee starts on or before first Monday of a month, effective the 1st day of the following month
  - If employee starts after first Monday of a month, effective the 1st day of the month following 30 days of employment
  - Includes adult children through month child turns 26
- Employee contribution taken out first pay check of month (for the following month's coverage)
  - Employee/Employer contribution amounts are based upon FTE% and Compensation Group and health plan and coverage level selected

Health Insurance Information

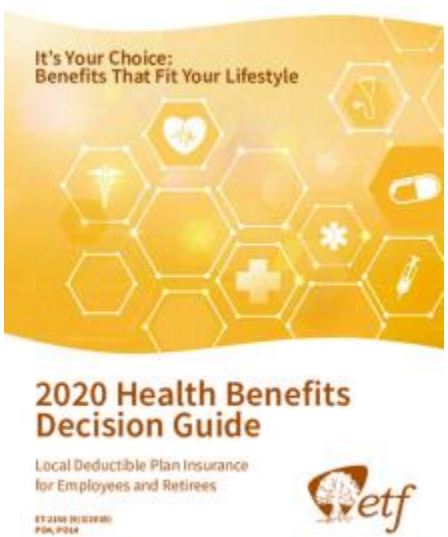
- City employees have 3 plans available in Dane County
  - Dean
  - Group Health Cooperative
  - Quartz-UW Health

  Plus
  - Standard plan
  - Other plans outside Dane County



Health Insurance Information

- Decision Guide
  - Includes summary of Uniform Benefits on Page 4 - provides information on benefit coverage
  - Annual open enrollment period for enrollment, changes, or cancellation without qualifying event
  - Midyear enrollment, changes, or cancellation requires qualifying event
  - More information can be found on individual Plan websites



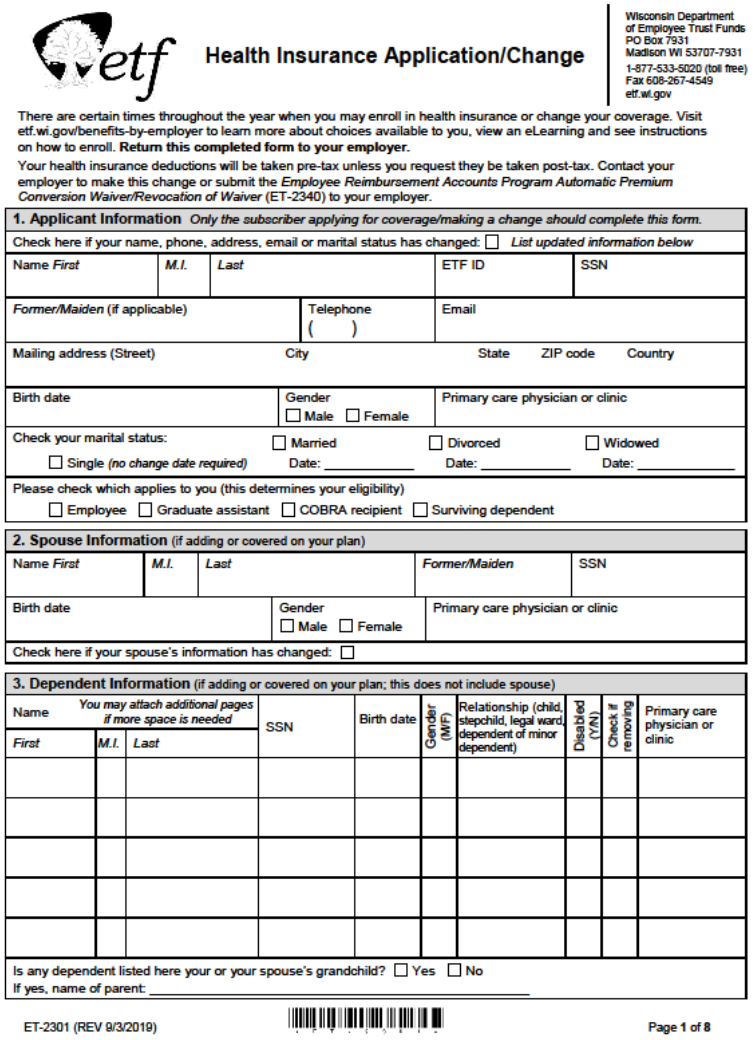
Prescription Pharmacy Manager

- Prescription Pharmacy Manager under all plans is Navitus
  - This is a third party administrator of your prescription drug program which negotiates rebates and discounts on behalf of the City's Group Health Insurance Program
  - Navitus member card is different from your health plan membership card
- Includes co-payments for most prescriptions
  - Based on formulary established by a committee of physicians and pharmacists
  - Includes four levels of co-payments:
    - Level 1 - $5
    - Level 2 - 20% of Navitus negotiated cost ($50 max per fill)
    - Level 3 - 40% of Navitus negotiated cost ($150 max per fill)
    - Level 4 - $50 Copay (must be filled at Lumicera or UW specialty pharmacies)

More Information on Page 4 of It's Your Choice Decision Guide

Health Insurance Application

- Page 1
  - Fill out all Section 1 boxes, making sure you include your Social Security Number (ETF ID may not have been assigned yet)
  - Under Section 2 - Complete if applicable (only required if spouse will be covered)
  - Section 3 - Complete if applicable (only required if child(ren) will be covered). Ensure all names, birth dates, and SS numbers are included in Dependent Information



etf **Health Insurance Application/Change**

Wisconsin Department of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

There are certain times throughout the year when you may enroll in health insurance or change your coverage. Visit etf.wi.gov/benefits-by-employer to learn more about choices available to you, view an eLearning and see instructions on how to enroll. **Return this completed form to your employer.**

Your health insurance deductions will be taken pre-tax unless you request they be taken post-tax. Contact your employer to make this change or submit the *Employee Reimbursement Accounts Program Automatic Premium Conversion Waiver/Revocation of Waiver* (ET-2340) to your employer.

1. Applicant Information *Only the subscriber applying for coverage/making a change should complete this form.*

Check here if your name, phone, address, email or marital status has changed: ☐ *List updated information below*

Name *First*	*M.I.*	*Last*	ETF ID	SSN

Former/Maiden (if applicable)	Telephone ( )	Email

Mailing address (Street) City State ZIP code Country

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic

Check your marital status: ☐ Married ☐ Divorced ☐ Widowed
☐ Single *(no change date required)* Date: _____ Date: _____ Date: _____

Please check which applies to you (this determines your eligibility)
☐ Employee ☐ Graduate assistant ☐ COBRA recipient ☐ Surviving dependent

2. Spouse Information (if adding or covered on your plan)

Name *First*	*M.I.*	*Last*	*Former/Maiden*	SSN

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic

Check here if your spouse's information has changed: ☐

3. Dependent Information (if adding or covered on your plan; this does not include spouse)

Name *You may attach additional pages if more space is needed*			SSN	Birth date	Gender (M/F)	Relationship (child, stepchild, legal ward, dependent of minor dependent)	Disabled (Y/N)	Check if removing	Primary care physician or clinic
First	*M.I.*	*Last*							

Is any dependent listed here your or your spouse's grandchild? ☐ Yes ☐ No
If yes, name of parent: _____

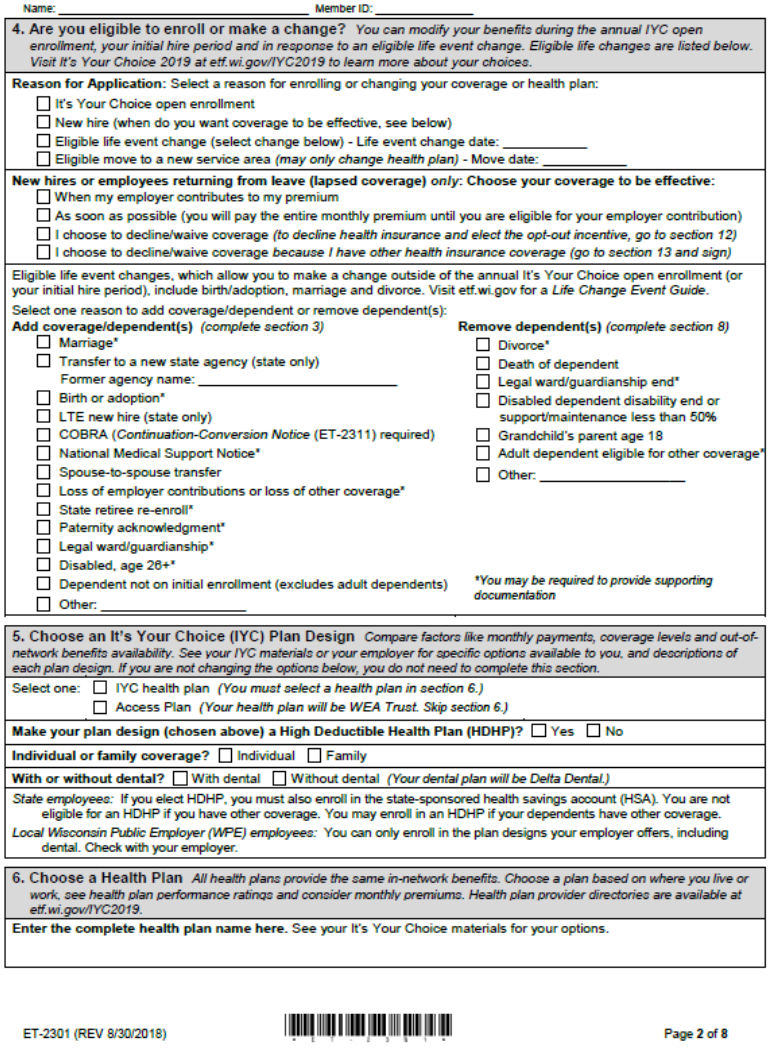
ET-2301 (REV 9/3/2019) Page 1 of 8

Health Insurance Application

- Page 2
  - **Section 4** – check *New Hire*
  - Check *When my employer contributes to my premium*, *I choose to decline,* or *As soon as possible* (if paying 1st month's premium – make arrangements with Central Payroll for payment)
  - **Section 5** – select *IYC* or *Access*, and indicate *Single or Family*

The City's Health insurance program does not include HDHP or Dental, so those boxes do not apply

  - **Section 6** –Write the name of the health plan that you selected (if not Access Plan)



Name: _____ Member ID: _____

4. Are you eligible to enroll or make a change? *You can modify your benefits during the annual IYC open enrollment, your initial hire period and in response to an eligible life event change. Eligible life changes are listed below. Visit It's Your Choice 2019 at etf.wi.gov/IYC2019 to learn more about your choices.*

Reason for Application: Select a reason for enrolling or changing your coverage or health plan:

- ☐ It's Your Choice open enrollment
- ☐ New hire (when do you want coverage to be effective, see below)
- ☐ Eligible life event change (select change below) - Life event change date: _____
- ☐ Eligible move to a new service area *(may only change health plan)* - Move date: _____

New hires or employees returning from leave (lapsed coverage) *only*: Choose your coverage to be effective:

- ☐ When my employer contributes to my premium
- ☐ As soon as possible (you will pay the entire monthly premium until you are eligible for your employer contribution)
- ☐ I choose to decline/waive coverage *(to decline health insurance and elect the opt-out incentive, go to section 12)*
- ☐ I choose to decline/waive coverage *because I have other health insurance coverage (go to section 13 and sign)*

Eligible life event changes, which allow you to make a change outside of the annual It's Your Choice open enrollment (or your initial hire period), include birth/adoption, marriage and divorce. Visit etf.wi.gov for a *Life Change Event Guide*.

Select one reason to add coverage/dependent or remove dependent(s):

Add coverage/dependent(s) *(complete section 3)*

- ☐ Marriage*
- ☐ Transfer to a new state agency (state only)
  Former agency name: _____
- ☐ Birth or adoption*
- ☐ LTE new hire (state only)
- ☐ COBRA (*Continuation-Conversion Notice* (ET-2311) required)
- ☐ National Medical Support Notice*
- ☐ Spouse-to-spouse transfer
- ☐ Loss of employer contributions or loss of other coverage*
- ☐ State retiree re-enroll*
- ☐ Paternity acknowledgment*
- ☐ Legal ward/guardianship*
- ☐ Disabled, age 26+*
- ☐ Dependent not on initial enrollment (excludes adult dependents)
- ☐ Other: _____

Remove dependent(s) *(complete section 8)*

- ☐ Divorce*
- ☐ Death of dependent
- ☐ Legal ward/guardianship end*
- ☐ Disabled dependent disability end or support/maintenance less than 50%
- ☐ Grandchild's parent age 18
- ☐ Adult dependent eligible for other coverage*
- ☐ Other: _____

**You may be required to provide supporting documentation*

5. Choose an It's Your Choice (IYC) Plan Design *Compare factors like monthly payments, coverage levels and out-of-network benefits availability. See your IYC materials or your employer for specific options available to you, and descriptions of each plan design. If you are not changing the options below, you do not need to complete this section.*

Select one: ☐ IYC health plan *(You must select a health plan in section 6.)*
☐ Access Plan *(Your health plan will be WEA Trust. Skip section 6.)*

Make your plan design (chosen above) a High Deductible Health Plan (HDHP)? ☐ Yes ☐ No

Individual or family coverage? ☐ Individual ☐ Family

With or without dental? ☐ With dental ☐ Without dental *(Your dental plan will be Delta Dental.)*

State employees: If you elect HDHP, you must also enroll in the state-sponsored health savings account (HSA). You are not eligible for an HDHP if you have other coverage. You may enroll in an HDHP if your dependents have other coverage.

Local Wisconsin Public Employer (WPE) employees: You can only enroll in the plan designs your employer offers, including dental. Check with your employer.

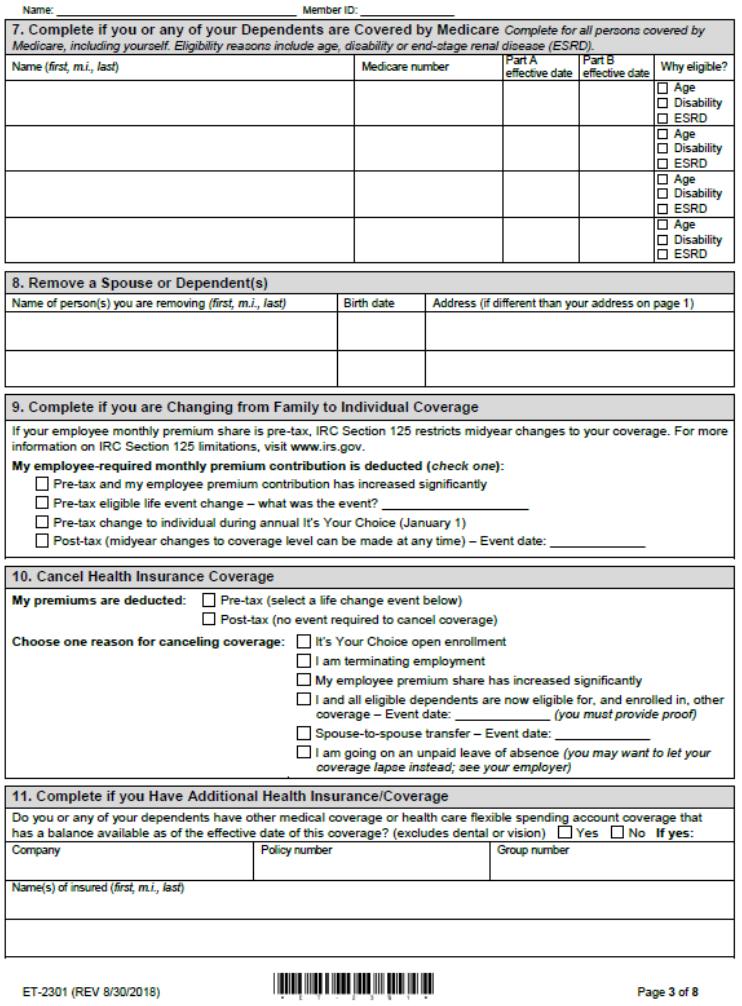
6. Choose a Health Plan *All health plans provide the same in-network benefits. Choose a plan based on where you live or work, see health plan performance ratings and consider monthly premiums. Health plan provider directories are available at etf.wi.gov/IYC2019.*

Enter the complete health plan name here. See your It's Your Choice materials for your options.

ET-2301 (REV 8/30/2018) Page 2 of 8

Health Insurance Application

- Page 3
  - Fill out all Section 7 if applicable.
  - Skip Sections 8-10.
  - Complete Section 11 if you have additional coverage that will overlap with the insurance provided by the City.



Name: _____ Member ID: _____

7. Complete if you or any of your Dependents are Covered by Medicare *Complete for all persons covered by Medicare, including yourself. Eligibility reasons include age, disability or end-stage renal disease (ESRD).*

Name (*first, m.i., last*)	Medicare number	Part A effective date	Part B effective date	Why eligible?
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD

8. Remove a Spouse or Dependent(s)

Name of person(s) you are removing *(first, m.i., last)*	Birth date	Address (if different than your address on page 1)

9. Complete if you are Changing from Family to Individual Coverage

If your employee monthly premium share is pre-tax, IRC Section 125 restricts midyear changes to your coverage. For more information on IRC Section 125 limitations, visit www.irs.gov.

My employee-required monthly premium contribution is deducted (*check one*):

- ☐ Pre-tax and my employee premium contribution has increased significantly
- ☐ Pre-tax eligible life event change – what was the event? _____
- ☐ Pre-tax change to individual during annual It's Your Choice (January 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time) – Event date: _____

10. Cancel Health Insurance Coverage

My premiums are deducted: ☐ Pre-tax (select a life change event below) ☐ Post-tax (no event required to cancel coverage)

Choose one reason for canceling coverage:

- ☐ It's Your Choice open enrollment
- ☐ I am terminating employment
- ☐ My employee premium share has increased significantly
- ☐ I and all eligible dependents are now eligible for, and enrolled in, other coverage – Event date: _____ *(you must provide proof)*
- ☐ Spouse-to-spouse transfer – Event date: _____
- ☐ I am going on an unpaid leave of absence *(you may want to let your coverage lapse instead; see your employer)*

11. Complete if you Have Additional Health Insurance/Coverage

Do you or any of your dependents have other medical coverage or health care flexible spending account coverage that has a balance available as of the effective date of this coverage? (excludes dental or vision) ☐ Yes ☐ No **If yes:**

Company	Policy number	Group number

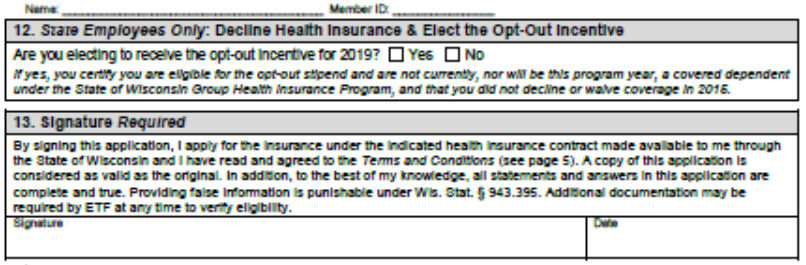
Name(s) of insured (*first, m.i., last*)

ET-2301 (REV 8/30/2018) Page 3 of 8

Health Insurance Application

- Page 4
  - Skip Section 12.
  - Sign and date Section 13.

Reminder – form must be turned in directly to Human Resources within 30 days from date of hire even if you are choosing to decline coverage!



Name: _____ Member ID: _____

12. *State Employees Only*: Decline Health Insurance & Elect the Opt-Out Incentive

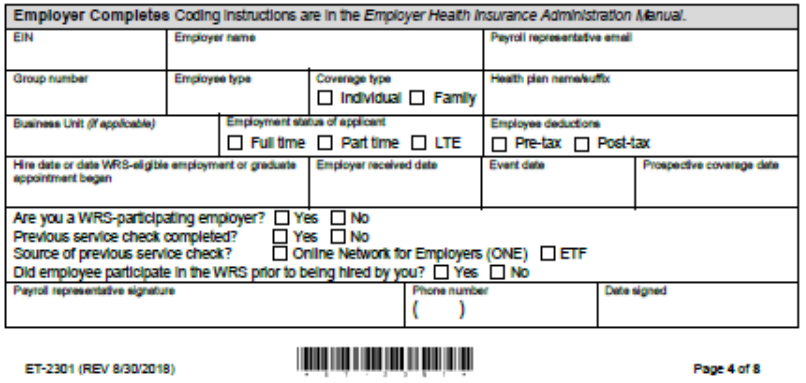
Are you electing to receive the opt-out incentive for 2019? ☐ Yes ☐ No

If yes, you certify you are eligible for the opt-out stipend and are not currently, nor will be this program year, a covered dependent under the State of Wisconsin Group Health Insurance Program, and that you did not decline or waive coverage in 2016.

13. Signature *Required*

By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and I have read and agreed to the *Terms and Conditions* (see page 5). A copy of this application is considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. Providing false information is punishable under Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.

Signature	Date



Employer Completes Coding instructions are in the *Employer Health Insurance Administration Manual*.

EIN	Employer name		Payroll representative email
Group number	Employee type	Coverage type ☐ Individual ☐ Family	Health plan name/suffix
Business Unit (*If applicable*)	Employment status of applicant ☐ Full time ☐ Part time ☐ LTE		Employee deductions ☐ Pre-tax ☐ Post-tax
Hire date or date WRS-eligible employment or graduate appointment began	Employer received date	Event date	Prospective coverage date

Are you a WRS-participating employer? ☐ Yes ☐ No
Previous service check completed? ☐ Yes ☐ No
Source of previous service check? ☐ Online Network for Employers (ONE) ☐ ETF
Did employee participate in the WRS prior to being hired by you? ☐ Yes ☐ No

Payroll representative signature	Phone number ( )	Date signed

ET-2301 (REV 8/30/2018) Page 4 of 8

Dental Insurance

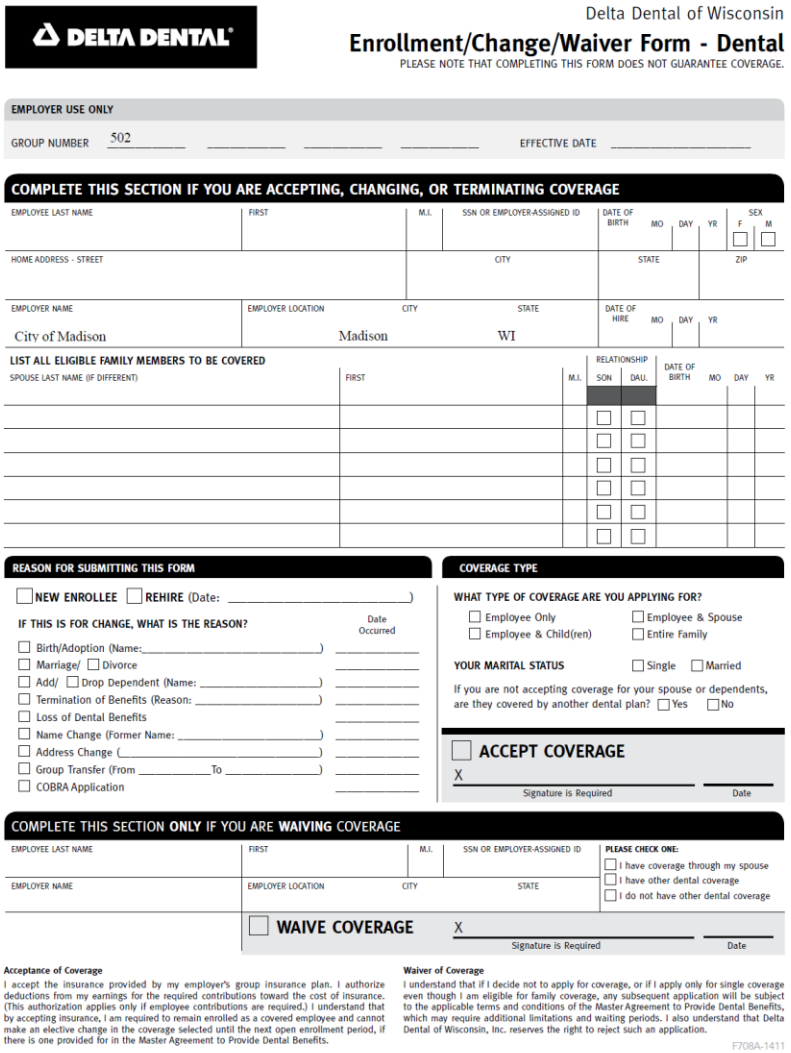
- Provider is Delta Dental
  - Available to all permanent City employees with no waiting period after effective date
  - Preferred Provider Organization (PPO)/Premier Plan – See Delta's website for PPO and Premier network providers
    - Three levels of benefits available
    - Highest level of benefits if you choose a Preferred (PPO) network Dentist
    - Second highest level of benefits if you choose a Premier network Dentist
    - Out of network Dentists result in lowest level of benefits
  - Premium taken out of second biweekly paycheck of the month (for the following month's coverage)

2020 Monthly Delta Dental Premiums

Employee Only: $35.94 (Single)	Employee+Spouse: $82.21
Employee+Child(ren): $82.89	Employee+Spouse+Child(ren): $124.79 (Family)

Dental Insurance Application

- Application
  - Complete paper application and return to HR within 30 days of date of hire even if waiving coverage!!
  - City group number is 502
  - Enrollment only upon hire or in Open Enrollment period or with qualifying event
  - Dental cannot be terminated mid-year except with qualifying event



DELTA DENTAL

Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER 502 _____ _____ _____ _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE

EMPLOYEE LAST NAME | FIRST | M.I. | SSN OR EMPLOYER-ASSIGNED ID | DATE OF BIRTH MO DAY YR | SEX F M

HOME ADDRESS - STREET | CITY | STATE | ZIP

EMPLOYER NAME: City of Madison | EMPLOYER LOCATION: Madison | CITY | STATE: WI | DATE OF HIRE MO DAY YR

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT) | FIRST | M.I. | RELATIONSHIP SON DAU. | DATE OF BIRTH MO DAY YR

REASON FOR SUBMITTING THIS FORM

☐ NEW ENROLLEE ☐ REHIRE (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON? | Date Occurred

- ☐ Birth/Adoption (Name:_____) _____
- ☐ Marriage/ ☐ Divorce _____
- ☐ Add/ ☐ Drop Dependent (Name: _____) _____
- ☐ Termination of Benefits (Reason: _____) _____
- ☐ Loss of Dental Benefits _____
- ☐ Name Change (Former Name: _____) _____
- ☐ Address Change (_____) _____
- ☐ Group Transfer (From _____To _____) _____
- ☐ COBRA Application _____

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

☐ Employee Only ☐ Employee & Spouse
☐ Employee & Child(ren) ☐ Entire Family

YOUR MARITAL STATUS ☐ Single ☐ Married

If you are not accepting coverage for your spouse or dependents, are they covered by another dental plan? ☐ Yes ☐ No

☐ **ACCEPT COVERAGE**

X _____ _____
Signature is Required | Date

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE LAST NAME | FIRST | M.I. | SSN OR EMPLOYER-ASSIGNED ID | PLEASE CHECK ONE:

- ☐ I have coverage through my spouse
- ☐ I have other dental coverage
- ☐ I do not have other dental coverage

EMPLOYER NAME | EMPLOYER LOCATION | CITY | STATE

☐ **WAIVE COVERAGE** X _____ _____
Signature is Required | Date

Acceptance of Coverage

I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

Waiver of Coverage

I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.

F708A-1411

Vision Insurance

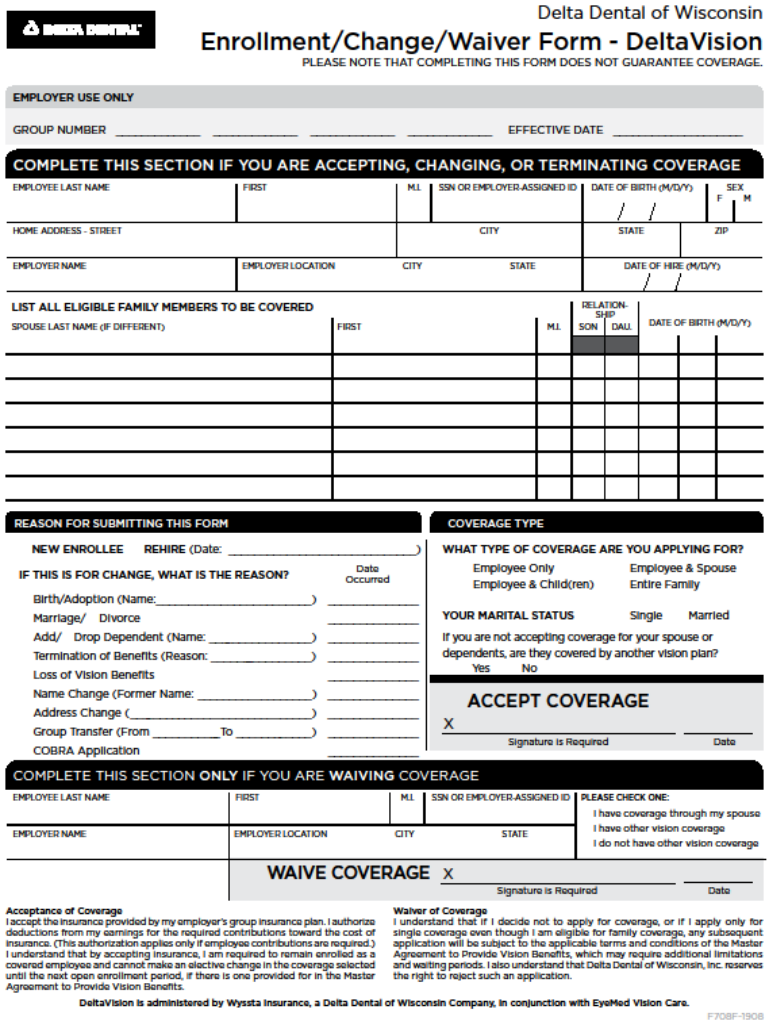
- Provider is DeltaVision
  - Available to all permanent City employees with no waiting period after effective date
  - Network Benefit/Non-Network Reimbursement – See Delta's website for Network providers
  - Premium taken out of second biweekly paycheck of the month (for the following month's coverage)

2020 Monthly DeltaVision Premiums

Employee Only: $5.97 (Single)	Employee+Spouse: $11.94
Employee+Child(ren): $12.19	Employee+Spouse+Child(ren): $18.16 (Family)

Vision Insurance Application

- Application
  - Complete paper application and return to HR within 30 days of date of hire even if waiving coverage!!
  - Enrollment only upon hire or in Open Enrollment period or with qualifying event
  - Vision insurance cannot be terminated mid-year except with qualifying event



Delta Dental of Wisconsin

Enrollment/Change/Waiver Form - DeltaVision

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

EMPLOYER USE ONLY

GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING, OR TERMINATING COVERAGE

EMPLOYEE LAST NAME | FIRST | M.I. | SSN OR EMPLOYER-ASSIGNED ID | DATE OF BIRTH (M/D/Y) | SEX F M

HOME ADDRESS - STREET | CITY | STATE | ZIP

EMPLOYER NAME | EMPLOYER LOCATION | CITY | STATE | DATE OF HIRE (M/D/Y)

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

SPOUSE LAST NAME (IF DIFFERENT) | FIRST | M.I. | RELATIONSHIP SON | DAU. | DATE OF BIRTH (M/D/Y)

REASON FOR SUBMITTING THIS FORM

NEW ENROLLEE REHIRE (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON? Date Occurred

- Birth/Adoption (Name:_____) _____
- Marriage/ Divorce _____
- Add/ Drop Dependent (Name: _____) _____
- Termination of Benefits (Reason: _____) _____
- Loss of Vision Benefits _____
- Name Change (Former Name: _____) _____
- Address Change (_____) _____
- Group Transfer (From _____ To _____) _____
- COBRA Application _____

COVERAGE TYPE

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?

Employee Only | Employee & Spouse | Employee & Child(ren) | Entire Family

YOUR MARITAL STATUS Single Married

If you are not accepting coverage for your spouse or dependents, are they covered by another vision plan? Yes No

ACCEPT COVERAGE X _____ _____ (Signature is Required / Date)

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

EMPLOYEE LAST NAME | FIRST | M.I. | SSN OR EMPLOYER-ASSIGNED ID | PLEASE CHECK ONE: I have coverage through my spouse; I have other vision coverage; I do not have other vision coverage

EMPLOYER NAME | EMPLOYER LOCATION | CITY | STATE

WAIVE COVERAGE X _____ _____ (Signature is Required / Date)

Acceptance of Coverage
I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Vision Benefits.

Waiver of Coverage
I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Vision Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.

DeltaVision is administered by Wyssta Insurance, a Delta Dental of Wisconsin Company, in conjunction with EyeMed Vision Care.

F708F-1908

Flexible Spending

FSA is offered through the City of Madison and administered by ConnectYourCare LLC (CYC). When you choose to enroll in a Healthcare FSA and/or Dependent Care FSA, you choose the annual dollar amount you want to contribute to each account based on your estimated expenses for the upcoming Plan Year. Your contributions will be deducted in equal amounts from each paycheck, **pre-tax, throughout the plan year. You will have access to your total Healthcare FSA annual contribution immediately at the start of the plan year. Dependent Care FSA funds are available up to the current account balance only.**

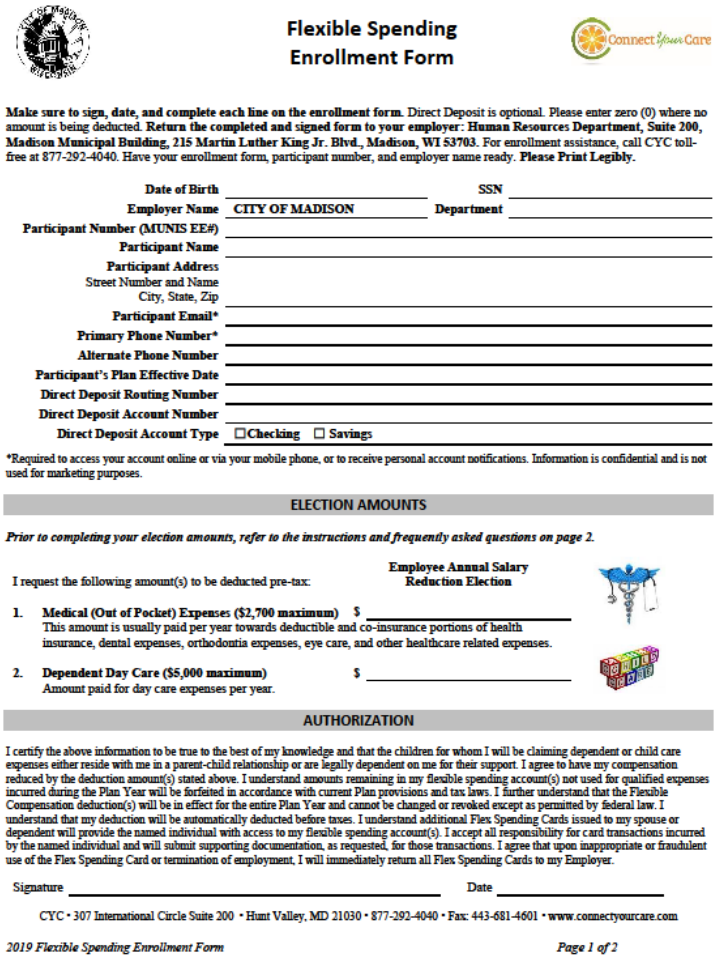
- Enrollment Forms must be completed and turned in to HR within 30 days of hire
- Annual enrollment form required each year if participating
- Healthcare Flexible Spending Account
  - $2,750.00 Maximum allowed annually (2020)
- Dependent Care Flexible Spending Account
  - $5,000.00 Maximum allowed annually (regardless of number of dependents)
  - $2,500.00 Maximum allowed annually for married individuals filing separately
- Flexible spending funds cannot be used toward employee health or dental premium contributions, but can be used for the annual deductibles.

Flexible Spending

- Process
  - Your CYC Card can be used to make eligible purchases directly from vendors
  - Requests for reimbursement can be made via CYC Mobile App, online, or paper form (fax or mail)
  - Reimbursements can be directly deposited in checking/savings account
  - Funds cannot be transferred between health and daycare accounts
  - Eligible claims must be incurred during the plan year (with grace period thru March 15) and submitted by March 31
  - For more information, including information on eligible purchases, see CYC's website www.connectyourcare.com

Flex Spending Enrollment Form

- Enrollment Form
  - Complete paper application and return to HR within 30 days of date of hire
  - Enrollment only upon hire or in Open Enrollment period or with qualifying event
  - Flex spending contributions cannot be terminated or changed mid-year except with qualifying event



Flexible Spending Enrollment Form

Make sure to sign, date, and complete each line on the enrollment form. Direct Deposit is optional. Please enter zero (0) where no amount is being deducted. **Return the completed and signed form to your employer: Human Resources Department, Suite 200, Madison Municipal Building, 215 Martin Luther King Jr. Blvd., Madison, WI 53703.** For enrollment assistance, call CYC toll-free at 877-292-4040. Have your enrollment form, participant number, and employer name ready. **Please Print Legibly.**

Date of Birth _____ **SSN** _____
Employer Name CITY OF MADISON **Department** _____
Participant Number (MUNIS EE#) _____
Participant Name _____
Participant Address
Street Number and Name _____
City, State, Zip _____
Participant Email* _____
Primary Phone Number* _____
Alternate Phone Number _____
Participant's Plan Effective Date _____
Direct Deposit Routing Number _____
Direct Deposit Account Number _____
Direct Deposit Account Type ☐ **Checking** ☐ **Savings**

*Required to access your account online or via your mobile phone, or to receive personal account notifications. Information is confidential and is not used for marketing purposes.

ELECTION AMOUNTS

Prior to completing your election amounts, refer to the instructions and frequently asked questions on page 2.

I request the following amount(s) to be deducted pre-tax: **Employee Annual Salary Reduction Election**

1. **Medical (Out of Pocket) Expenses ($2,700 maximum)** $ _____
   This amount is usually paid per year towards deductible and co-insurance portions of health insurance, dental expenses, orthodontia expenses, eye care, and other healthcare related expenses.
2. **Dependent Day Care ($5,000 maximum)** $ _____
   Amount paid for day care expenses per year.

AUTHORIZATION

I certify the above information to be true to the best of my knowledge and that the children for whom I will be claiming dependent or child care expenses either reside with me in a parent-child relationship or are legally dependent on me for their support. I agree to have my compensation reduced by the deduction amount(s) stated above. I understand amounts remaining in my flexible spending account(s) not used for qualified expenses incurred during the Plan Year will be forfeited in accordance with current Plan provisions and tax laws. I further understand that the Flexible Compensation deduction(s) will be in effect for the entire Plan Year and cannot be changed or revoked except as permitted by federal law. I understand that my deduction will be automatically deducted before taxes. I understand additional Flex Spending Cards issued to my spouse or dependent will provide the named individual with access to my flexible spending account(s). I accept all responsibility for card transactions incurred by the named individual and will submit supporting documentation, as requested, for those transactions. I agree that upon inappropriate or fraudulent use of the Flex Spending Card or termination of employment, I will immediately return all Flex Spending Cards to my Employer.

Signature _____ Date _____

CYC • 307 International Circle Suite 200 • Hunt Valley, MD 21030 • 877-292-4040 • Fax: 443-681-4601 • www.connectyourcare.com

2019 Flexible Spending Enrollment Form *Page 1 of 2*

Income Continuation Insurance

- Also called Wage Insurance, Disability Insurance
  - Provided through The Hartford
  - Insures employees up to 65% of regular salary ($1,875 maximum weekly benefit)
  - Benefits cover non-work-related injury and illness
  - Provides short- (3 yrs) and long-term benefits (up to retirement)
  - Must exhaust all available sick leave before payments start
- Enrollment
  - Coverage begins on date of enrollment
  - Enrollment required within 30 days of date of hire
  - Enrollment card must be filled out even if waiving coverage and turned in to HR
  - No other opportunity to enroll without underwriting

Income Continuation Insurance

- Wage Insurance Premiums
  - Taken out of second check of each month
  - Percent of premium based on combination of bi-weekly wages, accumulated sick leave, and sick leave used and accrued per annual tracking period (Sep-Sep), and adjusted annually
  - Premium paid by City if accumulated sick leave over 100 or 120 days, depending upon compensation group

Sick Leave Used	Sick Leave Accrued	Employee Pays
0-3.00 days	10.00-13.00 days	0%
3.01-4.00 days	9.00-9.99 days	20%
4.01-5.00 days	8.00-8.99 days	40%
5.01-6.00 days	7.00-7.99 days	60%
6.01-7.00 days	6.00-6.99 days	80%
7.01+ days	0-5.99 days	100%

Life Insurance

- Life Insurance (Employee, Dependent)
  - Provided through The Hartford
  - Employee coverage available in four levels
    - Basic (Highest annual earnings rounded up)
    - Basic + 50% Supplemental (1.5 X highest earnings)
    - Basic + 100% Supplemental (2 X highest earnings)
    - Basic + 200% Supplemental (3 X highest earnings)
  - Dependent coverage available in two levels
    - 1 unit ($5,000 per child and $10,000 for spouse)
    - 2 units ($10,000 per child and $20,000 for spouse)
- Enrollment
  - Within 30 days of date of hire, must return form even if waiving
  - Enrollment after initial enrollment period requires underwriting or qualifying event

Life Insurance

- "Term" insurance, meaning coverage for the term for which premium is paid
- Beneficiaries can be anyone, even an organization (not animals)
  - Beneficiary can be changed at any time by filling out change form
- Life Insurance Premium
  - Based on age and benefit amount
  - Inexpensive - increases over time
  - Taken from 1st paycheck of mo.
  - Payments continue into retirement
  - No premium after 70 if working, 65 if retired, and still get 25+ percent of Basic coverage paid!

Age Group	Cost per $1000 Coverage
Under 25	.05
25-29	.06
30-34	.08
35-39	.09
40-44	.10
45-49	.15
50-54	.23
55-59	.43
60-64	.57
65-69*	.57
Over 69*	**Free - basic coverage only**

***Over age 65 rates and coverage apply only if working**

Pension

- Defined Benefit Plan through Employee Trust Funds - Wisconsin Retirement System
  - Automatically enrolled
  - Comes out of paycheck each pay period pre-tax
- Eligibility
  - Must be 60% full time equivalent or more for permanent employees expected to work at least 12 months and hired after July 1, 2011
  - Hourly employees must work 12 months and 1,200 hrs
  - Employees hired after July 1, 2011, become vested after 5 years of WRS creditable service

Pension

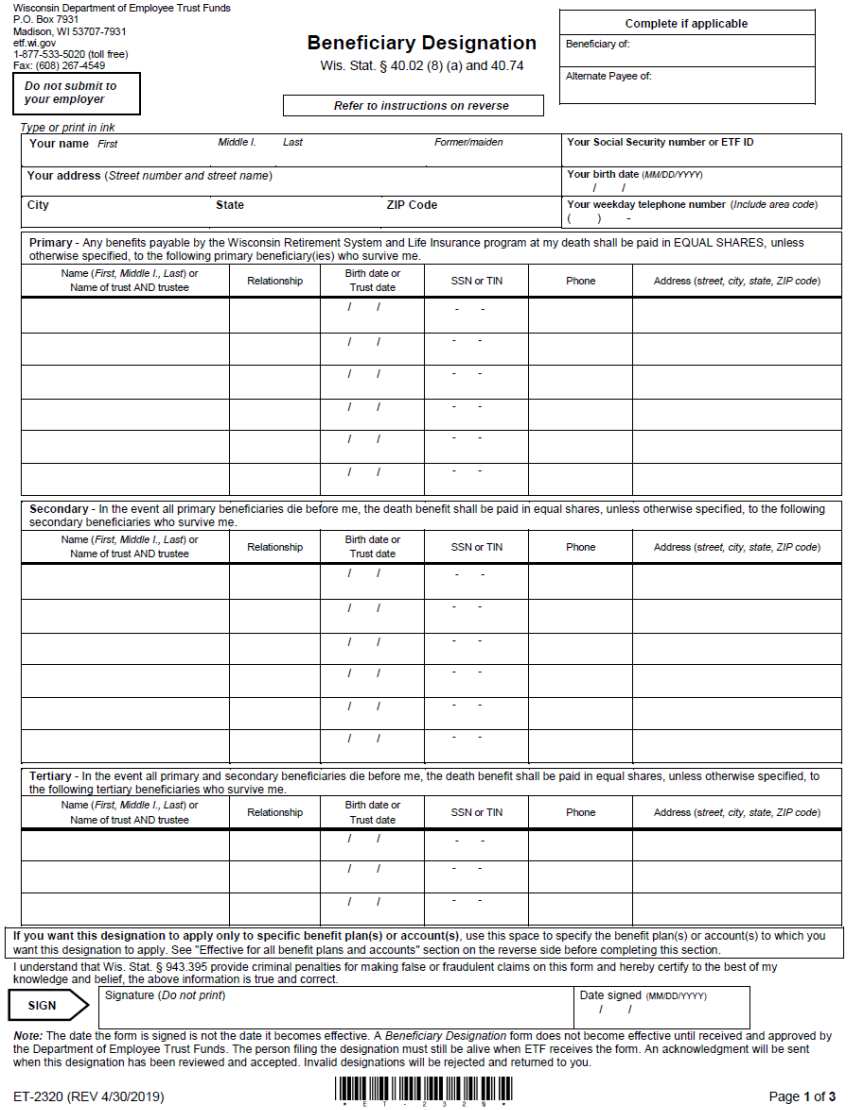
- Contributions
  - Mandatory
    - City pays employer portion of 6.75% (2020 rate)
    - Employee pays employee portion of 6.75% (2020 rate)
  - Voluntary
    - Additional contributions can be made after taxes to supplement regular WRS contributions
    - Additional contributions are subject to federal limits
  - Service Credit Purchase
    - You left WRS employment, took a separation benefit and returned to WRS employment. You may be eligible to buy **Forfeited Service.**
    - You are not a teacher and you began your WRS service before January 1, 1973. You may be eligible to buy **Qualifying Service.**
    - You have worked for a non-WRS public employer at the federal, state or local level. You may be eligible to buy **Other Governmental Service.**
    - **http://etf.wi.gov/publications/et4121.pdf**

Pension

- Funds
  - Contributions automatically placed in Core Trust Fund which is more stable and invested in a combination of bonds, fixed income securities and common stock
  - Employees can opt to place 50% of contributions in more risky variable fund which is invested in diversified equity portfolio
  - Employees can sign up for variable at any time but contributions to variable do not start until Jan. 1 of next year. Once variable is dropped, however, there is no re-entry
- Retirement
  - Normal age is 65, or 54 for protective service employees
  - Minimum age is 55, or 50 for protective service employees
  - No age reduction factor for monthly benefit if employee has 30 years creditable service and retires at age 57 or later
  - Intent is that benefit will provide total retirement income of between 50% and 85% of salary for career employee when added to Social Security

Pension

- Beneficiary Designation
  - If no form is filled out ETF will follow standard sequence
  - Incomplete form will not be considered valid
  - No white outs, cross outs, or changes are allowed
  - Rejected forms will be returned to you
  - Remember it is in effect until you change it! It is your responsibility to ensure it remains up-to-date and accurate



Wisconsin Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931
etf.wi.gov
1-877-533-5020 (toll free)
Fax: (608) 267-4549

Do not submit to your employer

Beneficiary Designation
Wis. Stat. § 40.02 (8) (a) and 40.74

Refer to instructions on reverse

Complete if applicable
Beneficiary of:
Alternate Payee of:

Type or print in ink

Your name *First*	*Middle I.*	*Last*	*Former/maiden*	**Your Social Security number or ETF ID**
Your address (*Street number and street name*)				**Your birth date** (*MM/DD/YYYY*) / /
City	**State**	**ZIP Code**		**Your weekday telephone number** (*Include area code*) ( ) -

Primary - Any benefits payable by the Wisconsin Retirement System and Life Insurance program at my death shall be paid in EQUAL SHARES, unless otherwise specified, to the following primary beneficiary(ies) who survive me.

Name (*First, Middle I., Last*) or Name of trust AND trustee	Relationship	Birth date or Trust date	SSN or TIN	Phone	Address (*street, city, state, ZIP code*)
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		

Secondary - In the event all primary beneficiaries die before me, the death benefit shall be paid in equal shares, unless otherwise specified, to the following secondary beneficiaries who survive me.

Name (*First, Middle I., Last*) or Name of trust AND trustee	Relationship	Birth date or Trust date	SSN or TIN	Phone	Address (*street, city, state, ZIP code*)
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		
		/ /	- -		

Tertiary - In the event all primary and secondary beneficiaries die before me, the death benefit shall be paid in equal shares, unless otherwise specified, to the following tertiary beneficiaries who survive me.

Name (*First, Middle I., Last*) or Name of trust AND trustee	Relationship	Birth date or Trust date	SSN or TIN	Phone	Address (*street, city, state, ZIP code*)
		/ /	- -		
		/ /	- -		
		/ /	- -		

If you want this designation to apply only to specific benefit plan(s) or account(s), use this space to specify the benefit plan(s) or account(s) to which you want this designation to apply. See "Effective for all benefit plans and accounts" section on the reverse side before completing this section.

I understand that Wis. Stat. § 943.395 provide criminal penalties for making false or fraudulent claims on this form and hereby certify to the best of my knowledge and belief, the above information is true and correct.

SIGN | Signature (*Do not print*) | Date signed (MM/DD/YYYY) / /

Note: The date the form is signed is not the date it becomes effective. A *Beneficiary Designation* form does not become effective until received and approved by the Department of Employee Trust Funds. The person filing the designation must still be alive when ETF receives the form. An acknowledgment will be sent when this designation has been reviewed and accepted. Invalid designations will be rejected and returned to you.

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Deferred Compensation

- 457 Plans
  - Similar to 401k but for public employees, with no City match to employee contributions
  - Voluntary investment opportunity offered through outside providers
    - ICMA-RC
    - Lincoln/Alliance Benefit Group (ABG)
  - Contribution limits of $19,500 or (over 50) $25,500
  - Contributions can be started, stopped, or changed at any time, and minimum contribution usually $25
  - While working for City, funds can only be withdrawn if approved through Emergency Withdrawal process
  - Contact ICMA or ABG for more information

Start saving early – TIME IS MONEY! The secret to getting rich slowly, but surely, is COMPOUND INTEREST!

Mayor APMs and Informational Documents

Employee Assistance Program

- EAP Services
  - Available to employees, families of employees, and employee spouses or significant others
  - Referral Services
    - Information, support and resource referral
    - Internal or external providers
    - Free and confidential
  - Critical Incident Stress Management
  - Supervisor and Union Steward Consultation
  - Training

EAP can help employees address such issues as:

- Family and couple conflicts
- Separation or divorce
- Parenting concerns
- Alcohol, drug, gambling or other addictions
- Emotional (such as depression or anxiety)
- Stress
- Child or elder care
- Legal problems or financial pressures
- Job performance
- Violence (e.g., verbal, physical or sexual abuse)
- Eating problems
- Grief from loss
- Impact of disability or chronic illness
- Housing

EAP Contact Information

Internal EAP

Tresa Martinez, EAP Manager	266-6561
Hailey Krueger, EAP Specialist	266-6561

External EAP

FEI Behavioral Health
1-800-236-7905 24/7
855-225-1367 TTY
www.feieap.com
(username: Madison)

Mayoral Administrative Procedure Memoranda & Other Information

- APMs
  - Apply to all City employees
  - Employees responsible for information therein
  - Available on EmployeeNet
    - 2-23 Drug and Alcohol Testing Policy/Drug-Free Workplace Memo
    - 3-5 Prohibited Harassment and/or Discrimination Policy
    - 2-33 Rules of Conduct
    - 2-25 Workplace Violence Prevention
    - 2-46 Prohibition of Weapons
    - 2-14 Designation of Family Partner
- Ethics Code
- Worker's Compensation
- IT Records Management

Employee Bus Pass

- Annual Bus Pass
  - Free to City Employees
  - Non-transferrable
  - May be asked to show City ID when using
  - Can be obtained in City Human Resources Office
  - No replacement fee
  - Guaranteed Ride taxi vouchers (six per year, $75 max per ride)

myrapid pass BETA

City Sponsored Committees

- Framework
  - Sponsored by the Mayor and City ordinance
  - Attendance is on City work time
  - Includes outreach activities within specific Committee focus

MAC
Multicultural Affairs Committee

www.cityofmadison.com/employeenet/multicultural-affairs-committee

Wic Women's Initiatives
COMMITTEE

http://www.cityofmadison.com/employeenet/womens-initiatives-committee

Discounts

- Nationwide Pet Insurance
- Select Overture Center Performances
- Cell Phone Plans (check with your provider)
- Dell Employee Purchase Program
- Cascade Marketplace Discount Program
- Trainings available through HR
- More info on EmployeeNet

Other City Employee Opportunities

- Combined Campaign (each Department competes for overall donations. Examples: Bake Sale, Bucky Book Sale, Brat Sale)
- All City Bowling Tournament (January)
- Red Cross Blood Drives (4x per year)
- Individual Agency Groups (Volleyball, Softball, book clubs, golf leagues)
- Union/Employee Association Activities

Employee Associations Video.url

Today's Mandatory Paperwork

- Orientation checklist – signed and dated
- W-4 and Wisconsin Withholding Forms
- I-9 Form
- Self Declaration of Disability Form
- Emergency Contact Form
- Self Identification Form
- Optional: Any enrollment forms that you want to turn in today

*All other enrollment forms should be returned to Human Resources, Ste 261 MMB

QUESTIONS?

Bill Wick or Sherry Severson

608-266-4615

wwick@cityofmadison.com

sseverson@cityofmadison.com