Employee Data Collection Form

University of Maryland
CENTER FOR ENVIRONMENTAL SCIENCE

1. Employee Information

SS#:

Last Name:	**First Name:**	**Middle Name:**
Suffix Name (check one): II ☐ III ☐ IV ☐ V ☐ Jr. ☐ Sr. ☐ None ☐	**Birth Date**:_____	**Racial Identity:** ☐ Not Reported ☐ Amer Indian/Alaska Nat ☐ Black/African American ☐ Asian/Pacific Islander ☐ Hispanic ☐ White
Gender: ☐ Female ☐ Male	**Citizenship/Visa Status:** _____	**Citizenship Country** _____
Visa or Perm. Res. #:_____	**Check Distribution Code:** _____	**Retired form State:** _____
Military Status (check one): ☐ Non-Veteran ☐ Veteran ☐ Vietnam Veteran ☐ Active Reserve ☐ Inactive Reserve ☐ Retired ☐ Special Disability	**Highest Education Level (check one):** ☐ Less than 7th grade ☐ 7th, 8th, 9th grade completed ☐ 10th, 11th grade completed ☐ High School Grad or GED ☐ Some Bus. Sch. College (HS Grad) ☐ Associate Degree Earned ☐ Bachelor's Degree ☐ Some Graduate Study ☐ Advanced Grad Specialist (AGS) ☐ Master's Degree earned ☐ Doctoral Degree earned ☐ First Professional Degree earned	

2. Employee Address Information

Business/Office Address:

Business Phone Number:

Permanent Address:

City: **County:** **State:** **Zip:**

3. Employee Email Address

Primary Email Address: **Home Phone:**

4. Employee Education Information

State Degree Earned: **Institution:**

Degree: **Degree Date:**

5. Emergency Contact Information

Contact Name: **Relationship:**

Address:

Home Phone Number: **Cell Phone/Pager:**

Work Phone Number: **Email Address:**

2009 EMPLOYEE WITHHOLDING ALLOWANCE CERTIFICATE
FOR MARYLAND STATE GOVERNMENT EMPLOYEES ONLY

Form W-4
Department of the Treasury
Internal Revenue Service

Form MW 507
Comptroller of Maryland

Please complete form in black ink. 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.

Section 1 - Employee Information

Payroll System (*check one*)	Name of Employing Agency		
RG ☐ CT ☐ UM ☐	UMCES		
Agency Number	Social Security Number	Employee Name	
360234			
Home Address (number and street or rural route)		Address Continued (apartment number, if any)	
City	State	Zip Code	County of Residence (*required*)

Section 2 - Federal Withholding Form W-4

The federal worksheet is available online at http://www.irs.gov/pub/irs-pdf/fw4.pdf

3 Single ☐ Married ☐ Married, but withhold at higher Single Rate ☐
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

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 new card. ➤

5	Total number of allowances you are claiming (from page 1 or page 2 of the federal worksheet)	**5**
6	Additional amount, if any, you want withheld from each paycheck	**6** $
7	I claim exemption from withholding for 2009, 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**

Section 3 - Maryland Withholding Form MW 507

The Maryland worksheet is available online at http://forms.marylandtaxes.com/current_forms/MW507.pdf

Withhold at Single Rate ☐ Married (surviving spouse or unmarried Head of Household) Rate ☐ Married, but withhold at Single Rate ☐

1. Total number of exemptions you are claiming from Maryland worksheet 1. _____

2. Additional withholding per pay period under agreement with employer 2. _____

3. I claim exemption from withholding because I do not expect to owe Maryland tax. See instructions below and check boxes that apply.

   ☐ a. Last year I did not owe any Maryland income tax and had a right to a full refund of all income tax withheld.
   AND
   ☐ b. This year I do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. (This includes seasonal and student employees whose annual income will be below the minimum filing requirement).

   If both **a** and **b** apply, enter year applicable _____ (year effective) Enter "EXEMPT" here 3. _____

4. I claim exemption from withholding because I am domiciled in one of the folowing states. Check state that applies.

   ☐ Pennsylvania (indicate township/borough under **Address Continued** in section 1 above.) ☐ Virginia

I further certify that I do not maintain a place of abode in Maryland as described in the instructions on page 2 of the worksheet.

Enter "EXEMPT" here 4. _____

Section 4 - Employee Signature

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. I further certify that I am entitled to the number of withholding allowances claimed on line 1 above, or if claiming exemption from withholding, that I am entitled to claim the exempt status on line 3 or line 4, whichever applies.

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

Employer's name and address (including zip code) (For employer use only)	Federal Employer identification number
Central Payroll Bureau **P.O. Box 2396** **Annapolis, MD 21404**	52-6002033 **(For State of Maryland - CPB use only)**

Important: The information you supply must be complete. This form will replace in total any certificate you previously submitted.
Web Site - http://compnet.comp.state.md.us/cpb

2009 FORM W-4

INSTRUCTIONS - PAGE 1

EMPLOYEE'S FEDERAL WITHHOLDING ALLOWANCE

Form W-4 (2009)

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 2009 expires February 16, 2010. **See Pub. 505,** Tax Withholding and Estimated Tax.

Note: *You cannot claim exemption from withholding if (a) your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends) and (b) another person can claim you as a dependent on their tax return.*

Basic instructions. If you are not 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-earner/multiple job situations. Complete all worksheets that apply.

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

Head of household. Generally, you may claim head of household filing status on your tax return only if you are unmarried and pay more than 50 percent 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 infomation.

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. 919,** How Do I Adjust My Tax Withholding, 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. 919** to find out if you should adjust your withholding on form W-4 or W-4P.

Two earners/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. 919 for details.

Nonresident alien. If you are a nonresident alien, see the **Instructions for Form 8233** before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the dollar amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Recent name change? If your name on line 1 differs from that shown on your social security card, call 1-800-772-1213 to initiate a name change and obtain a social security card showing your correct name.

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 are single and have only one job; or • You are married, have only one job, and your spouse does not 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 $1,800 of **child or dependent care expenses** for which you plan to claim a credit . . (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	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 $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child plus "1" **additional** if you have six or more eligible children.	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 have **more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($25,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction

1 Enter an estimate of your 2009 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions. (For 2009, you may have to reduce your itemized deductions if your income is over $166,800 ($83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . 1 $

2 Enter: { $11,400 if married filing jointly or qualifying widow(er) / $ 8,350 if head of household / $ 5,700 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2009 adjustments to income and any additional standard deduction. (Pub. 919) . . . . . 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) . 5 $

6 Enter an estimate of your 2009 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 $3,500 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 $50,000 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 4–9 below to calculate 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 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. 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

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
$0 - $4,500	0	$0 - $6,000	0
4,501 - 9,000	1	6,001 - 12,000	1
9,001 - 18,000	2	12,001 - 19,000	2
18,001 - 22,000	3	19,001 - 26,000	3
22,001 - 26,000	4	26,001 - 35,000	4
26,001 - 32,000	5	35,001 - 50,000	5
32,001 - 38,000	6	50,001 - 65,000	6
38,001 - 46,000	7	65,001 - 80,000	7
46,001 - 55,000	8	80,001 - 90,000	8
55,001 - 60,000	9	90,001 - 120,000	9
60,001 - 65,000	10	120,001 and over	10
65,001 - 75,000	11		
75,001 - 95,000	12		
95,001 - 105,000	13		
105,001 - 120,000	14		
120,001 and over	15		

Table 2

Married Filing Jointly		All Others	
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 - $65,000	$550	$0 - $35,000	$550
65,001 - 120,000	910	35,001 - 90,000	910
120,001 - 185,000	1,020	90,001 - 165,000	1,020
185,001 - 330,000	1,200	165,001 - 370,000	1,200
330,001 and over	1,280	370,001 and over	1,280

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. The Internal Revenue Code requires this information under sections 3402(f)(2)(A) and 6109 and their regulations. 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 also 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 using it 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.

2009 INSTRUCTIONS

EMPLOYEE'S STATE OF MARYLAND WITHHOLDING ALLOWANCE

COMPTROLLER of MARYLAND
Serving the People

Revenue Administration Division

Line 1
Employee Withholding Allowance Certificate

a. Number of personal exemptions (total exemptions on lines A, C and D of the federal W-4 or W-4A worksheet a._____

b. Number of additional exemptions for dependents over 65 years of age b._____

c. Number of additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable childcare expenses, qualified retirement contributions, business losses and employee business expenses for the year. c._____

d. Number of additional exemptions for taxpayer and/or spouse at least 65 years of age and/or blind d._____

e. Total - add lines a through d and enter here and on line 1(Form MW507) e._____

Exemptions for dependents - to qualify as your dependent, you must be entitled to an exemption for the dependent on your federal income tax return for the corresponding tax year.

Additional exemptions for dependents over 65 years of age - An additional exemption is allowed for dependents who are 65 years of age or older.

Additional exemptions - You may claim additional exemptions for certain items, including estimated itemized deductions, alimony payments, allowable child care expenses, qualified retirement contributions, business losses and employee business expenses for the year. One additional withholding exemption is permitted for each $3,200 of estimated itemized deductions or adjustments to income that exceed the standard deduction allowance.

NOTE :Standard deduction allowance is 15% of Maryland adjusted gross income with a minimum of $1,500 and a maximum of $2,000 for each taxpayer.

Additional exemptions for taxpayer and/or spouse - An additional $1,000 may be claimed if the taxpayer and/or spouse is at least 65 years of age and/or blind on the last day of the tax year.

Line 2
Additional withholding per pay period under agreement with employer - if you are not having enough tax withheld, you may ask your employer to withhold more by entering an additional amount on Line 2.

.

Line 3
Who may claim exemption from withholding of income tax - You may be entitled to claim an exemption from the withholding of Maryland income tax if:

a. last year you did not owe any Maryland income tax and had a right to a full refund of any tax withheld; and
b. this year you do not expect to owe any Maryland income tax and expect to have the right to a full refund of all income tax withheld. If you are eligible to claim this exemption your employer will not withhold Maryland income tax from your wages.

Students and seasonal employees whose annual income will be below the minimum filing requirements (annual income less than **$8,950 for 2009**) should claim exemption from withholding. This provides more income throughout the year and avoids the necessity of filing a Maryland income tax return.

Line 4
Certification of nonresidence in the State of Maryland -This line is to be completed by residents of Pennsylvania and Virginia who who are employed in Maryland and do not maintain a place of abode in Maryland for 183 days or more. .

Line 4 is *not* to be used by residents of other states who are working in Maryland, because such persons are liable for Maryland income tax and withholding from their wages is required.

If you are domiciled in the District of Columbia Pennsylvania or Virginia and maintain a place of abode in Maryland for 183 days or more, you become a statutory resident of Maryland and you are required to file a resident return with Maryland reporting your total income. You must apply to your domicile state for any tax credit to which you may be entitled under the reciprocal provisions of the law.

If your are domiciled in West Virginia, you are not required to pay Maryland income tax on wage or salary income, regardless of the length of time you may have spent in Maryland.

GENERAL INSTRUCTIONS
Federal Privacy Act Information - Social Security numbers must be included, The mandatory disclosure of your social security number is authorized by the provisions set forth in the Tax-General Article of the Annotated Code of Maryland. Such numbers are used primarily to administer and enforce the individual income tax laws and to exchange income tax information with the Internal Revenue Service, other states and other tax officials of this state. Information furnished to other agencies or persons shall be used solely for the purpose of administering tax laws or the specific laws, administered by the person having statutory right to obtain it.

Duties and Responsibilities of Employer - Retain this certificate with your records. You are required to submit a copy of this certificate to the Compliance Division, Compliance Programs Section, 301 West Preston Street, Baltimore, MD 21201, when received if:

1. you have any reason to believe this; certificate is incorrect;
2. the employee claims more than 10 exemptions;
3. the employee claims exemptions from withholding because he/she had no tax liability for the preceding tax year, expects to incur no tax liability this year and the wages are expected to exceed $200 a week; or
4. the employee claims exemptions from withholding on the basis on nonresidence.

Upon receipt of any exemption certificate (For MW 507), the Compliance Division will make a determination and notify you if a change is required.

Once a certificate is revoked by the comptroller, the employer must send any new certificate from the employee to the comptroller for approval before implementing the new certificate.

If an employee claims exemption under 3 above, a new exemption certificate must be filed by February 15th of the following year.

Duties and Responsibilities of Employee - If, on any day during the calendar year, the number of withholding exemptions that the employee is entitled to claim is less than the number of exemptions claimed on the withholding certificate in effect, the employee shall file a new withholding exemption certificate with the employer within 10 days after the change occurs.

For additional information please call

410-767-1300
or
toll free 1-800-492-1751

or visit our Web sit at

www.marylandtaxes.com

OMB No. 1615-0047; Expires 08/31/12

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
City	State	Zip Code	Social Security #

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):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature | Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

List A	OR	List B	AND	List C
Document title:				
Issuing authority:				
Document #:				
Expiration Date *(if any)*:				
Document #:				
Expiration Date *(if any)*:				

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title
Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*		Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

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	Date *(month/day/year)*

State of Maryland
Payroll Direct Deposit Authorization

☐ **Regular** ☐ **Contract** ☑ **University of MD**

Payroll System (check one)

			–			–				

Social Security Number

Employee's Name (please print)

3	6	0	2	3	4

Agency Code

UMCES

Agency Name (please print)

I authorize the State of Maryland Central Payroll Bureau to take the following action with my net salary:

(Check One)

CPB Use Only

Effective PPE:

☐ 1. Deposit directly to my checking account
(Will take at least two pay periods to allow for pre-note process)

☐ 2. Change bank and/or checking account to which my net salary is deposited
(Cancel of old account will occur within 21 days of receipt at CPB; you will receive 2 payroll checks until the new account is established)

☐ 3. Discontinue direct deposit and issue a payroll check instead
(Will occur within 21 days) **Do not close account until payroll check is issued**

Bank Name:
(Omit if action 3 is checked)

Copy directly from your personal check. Do not include your check number.
Do not use your deposit slip number. Verify carefully.

Bank Number

Checking Account Number

I authorize the State of Maryland to deposit my net salary to the bank and account named above. This authorization is to remain in force until the State of Maryland receives written notification from me of its termination in time and manner that allows the State and the bank a reasonable opportunity to act upon it. In the event that the State of Maryland notifies the bank that funds to which I am not entitled have been deposited to my account in error, I authorize and direct the bank to return said funds to the State as soon as possible. If the funds erroneously deposited to my account have been drawn from that account so that return of those funds by the bank to the State is not possible, I authorize the State to recover those funds by setting off the amount erroneously paid me from any future payments from the State until the amount of the erroneous deposit has been recovered, in full.

Date _____ Employee signature _____ Daytime phone number _____

Instructions:

- *Only one checking account is permitted for direct deposit.*
- Type or print only (except signature).
- Use black ink only.
- Complete all blocked areas in the top part of form except for the section "CPB use only."
- Read authorization and sign the completed form. **Unsigned or Incomplete forms will be returned.**
- Deposit amount will be *full net amount* of pay.
- If changing your bank and or checking account, you will receive a payroll check until new direct deposit becomes effective.
- Do not send a voided blank check.
- Send completed form to Central Payroll Bureau, P.O. Box 2396, Annapolis, MD 21404. Phone 410-260-7401.

Agency Code: _ _ _ _ _ _
Check Dist. Code _ _ _ _ _ _

STATE OF MARYLAND

ACTIVE & SATELLITE EMPLOYEES
HEALTH BENEFITS ENROLLMENT FORM FOR JULY 2008-JUNE 2009

PERSONAL DATA *PLEASE PRINT CLEARLY*

Name:
Address:
City **State** **Zip Code**

Home Phone: ( ) __ __ __- __ __ __ __
Work Phone: ( ) __ __ __ - __ __ __ __
Cell Phone: ( ) __ __ __ - __ __ __ __

Pay Center:
Pay Cycle:

Social Security Number: __ __ __ /__ __ / __ __ __ __

Date of Birth: ____/____/_____

PLEASE COMPLETE: (MARK ALL APPROPRIATE CIRCLES)

I work full-time or 50% or more of the normal week:

I work_____hrs. per week

Pay Center
○ Central Payroll
○ University of MD
○ Satellite (specify agency: _____)

I am paid:
○ Biweekly
○ Monthly

I am 21-Pay Faculty
○ Yes
○ No

Sex:
○ Male
○ Female

Marital Status:
○ Single
○ Married
○ Divorced
○ Limited Divorce/ Legally Separated
○ Widowed

EMPLOYEE STATUS

○ New Employee. Entry on duty date: _____
○ Return from leave of absence/LAW Date: _____
○ Transfer from: _____ (Agency Code) to _____ (Agency Code)
○ Employee requesting change due to change in family status
○ Employee ineligible (e.g., change to part-time less than 50%)

Note on Retroactive Adjustments:
Employees must contact their Agency Benefits Coordinator to file a Retroactive Adjustment to backdate coverage within 60 days of the date of the Change in Status or Entry on Duty. Newborn Retroactive Adjustments are required to be backdated to date of birth.

ENROLLMENT/CHANGE ACTION REQUESTED

○ New Enrollment (New employee/return from LAW):
○ Change in family status
  ○ Add spouse or dependent because of:
    ○ Marriage Date: _____
    ○ Birth/Adoption/Appointed Permanent Legal Guardian Date: _____
    ○ Other: _____
  ○ Remove spouse or dependent because of:
    ○ Divorce/Limited Divorce/Legal Separation Date: _____
    ○ Death Date: _____ *(Attach copy of Death Certificate)*
    ○ Dependent no longer eligible-explain: _____
  ○ Other Change: _____
    ○ Cancel all coverage-explain: _____
    _____

DEPENDENT INFORMATION *PLEASE PRINT - DEPENDENTS INCLUDE YOUR SPOUSE AND CHILDREN*

YOU MAY USE THIS SECTION FOR ADDITIONS (A), CHANGES (C) OR DELETIONS (D) TO YOUR EXISTING HEALTH BENEFITS FILE. COMPLETE ALL INFORMATION FOR EACH ENTRY. PLEASE PRINT CLEARLY.

A/C/D	*LAST NAME*	*FIRST NAME*	*MI*	*SEX*	*BIRTH DATE*	*RELATIONSHIP*	*SOCIAL SECURITY NO.*	*COVER THIS DEPENDENT FOR: HEALTH*	*DRUG*	*DENTAL*

NOTE: If you are adding or removing a dependent, please see your Benefits Book for dependent documentation requirements. Tax-qualified dependent children age 25 and over must be disabled prior to reaching age 25.

ENROLLMENT FOR JULY 2008-JUNE 2009

Medical Benefits

OPTIONS
- ○ New Enrollment or Change in Enrollment
- ○ Addition or removal of a dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & one child; name: _____
- ○ Individual & spouse
- ○ Individual & two or more
- ○ End Stage Renal (ESRD) (Complete Medicare Information below)

MEDICAL PLANS-Choose only one

PPO Plans:
- ○ BC/BS PPO
- ○ MLH Eagle PPO

POS Plans:
- ○ Aetna POS
- ○ BC/BS MD POS
- ○ MD IPA Preferred POS

HMO Plans:
- ○ BlueChoice HMO
- ○ Kaiser HMO
- ○ Optimum Choice HMO

NOTE: Medicare Part D is voluntary. See the Notice of Creditable Coverage letter for the State's prescription drug plan in the Benefits Book.

NAMES OF INDIVIDUALS WITH MEDICARE	*MEDICARE NUMBER*	*PART A (Hospital Claims) Effective Date*	*PART B (Medical Claims) Effective Date*	*PART D (Prescription Drug) Effective Date*	*MEDICARE DUE TO (✓):* *Age 65*	*Disabled*	*ESRD*
Employee							
Spouse							
Dependent Child							
Dependent Child							

NOTE: Vision and Mental Health/Substance Abuse benefits <u>are available</u> if enrolled in a medical plan. Medical plans <u>do not include</u> Prescription Drug or Dental coverage. See the following sections.

Prescription Coverage

OPTIONS
- ○ New enrollment
- ○ Addition or removal of dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & one child; name: _____
- ○ Individual & spouse
- ○ Individual & two or more

Dental Coverage

OPTIONS
- ○ New enrollment or change in plan
- ○ Addition or removal of dependent
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Individual Only
- ○ Individual & one child; name: _____
- ○ Individual & spouse
- ○ Individual & two or more

DENTAL PLANS

Check only one dental plan:
- ○ Dental Benefits Providers Dental HMO
- ○ United Concordia Dental HMO
- ○ United Concordia Dental PPO

Personal Accident and Dismemberment

OPTIONS
- ○ New Enrollment or addition/removal of dependent
- ○ Change of benefit amount - select benefit amount
- ○ No, I do not want to start this benefit
- ○ Cancel current coverage

COVERAGE LEVEL
- ○ Employee only coverage
- ○ Family coverage

BENEFIT AMOUNT
- ○ $100,000
- ○ $200,000
- ○ $300,000

Flexible Spending Accounts – SELECTED AMOUNTS ARE PER PAY CHECK

<u>YOU MUST COMPLETE THIS SECTION IF YOU WANT TO PARTICIPATE IN A FLEXIBLE SPENDING ACCOUNT IN JULY 2008-JUNE 2009</u>

HEALTH CARE

OPTIONS
- ○ **Enroll** in Health Care Spending Account
- ○ **Cancel** Health Care Spending Account

$ ☐☐☐.☐☐ *Write in dollar amount **per deduction***

DAY CARE

OPTIONS
- ○ **Enroll** in Day Care Spending Account
- ○ **Cancel** Day Care Spending Account

$ ☐☐☐.☐☐ *Write in dollar amount **per deduction***

If you will be retiring before July 1, 2009, please be advised that only expenses incurred prior to retirement can be considered for reimbursement. Only expenses for tax-qualified dependents may be reimbursed.

See Benefits Book for Minimum/Maximum deduction amounts. Check with your Benefits Coordinator for your number of deductions, i.e., 24, 21 or 19.
Reminder: This is not a yearly deduction amount. THIS IS THE AMOUNT PER DEDUCTION IN JULY 2008-JUNE 2009.

State Life Insurance Plan

EMPLOYEE

OPTIONS

- ○ Yes, I want to enroll as a new enrollee in life insurance. Select benefit amount.
- ○ I am currently enrolled in life insurance and making a change. Select benefit amount.
- ○ No, I do not want to start life insurance for myself.
- ○ Cancel employee life insurance.

Choose a Coverage Amount in increments of $10,000 for yourself:

STOP-If you choose an amount greater than $50,000, you must fill out a Life Insurance Statement of Health for yourself. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for yourself.

Fill in the amount of Benefit

$ ☐☐☐,■■■

SPOUSE

SECTION 2: SPOUSE INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself**. The amount requested for your spouse can be up to 50% of the amount selected for you, the employee.

OPTIONS

- ○ Having selected life insurance for myself, I wish to have life insurance on my spouse. Select benefit amount.
- ○ I currently have life insurance for my spouse and am making a change. Select benefit amount.
- ○ No, I do not want to start life insurance on my spouse.
- ○ Cancel spouse life insurance on my spouse.

Choose a Coverage Amount in increments of $5,000 for your spouse- up to 1/2 of the amount chosen for yourself:

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for your spouse. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for your spouse.

Fill in the amount of Benefit

$ ☐☐☐,■■■

CHILDREN

SECTION 3: CHILDREN INSURANCE

NOTE: You cannot enroll your family members unless you, the employee, are enrolled. **You cannot select an amount for your dependents greater than 50% of the amount selected for yourself**. The amount requested for your children can be up to 50% of the amount selected for you, the employee.

OPTIONS

- ○ Having selected life insurance on my myself, I wish to have life insurance for my child(ren). Select benefit amount.
- ○ I currently have life insurance for my child(ren) and am making a change. Select benefit amount.
- ○ No, I do not want to start life insurance on my child(ren).
- ○ Cancel child life insurance on my child(ren).

Choose a Coverage Amount in increments of $5,000 for your child(ren)- up to 1/2 of the amount chosen for yourself:

STOP-If you choose an amount greater than $25,000, you must fill out a Life Insurance Statement of Health for each covered child. Please go to our website www.dbm.maryland.gov to download the Statement of Health form for each covered child.

Fill in the amount of Benefit

$ ☐☐☐,■■■

Employee Signature

Please enroll me for the Flexible Benefits indicated on this form. I understand the benefits and limitations provided by the various plans and I authorize the State of Maryland to make the necessary adjustments in my pay based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents. The personal information provided on this enrollment form is warranted to be complete, accurate, and in accordance with Department of Budget and Management (DBM) regulations. **I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in status permitted by Section 125 of the Internal Revenue Code.**

I understand that if I have enrolled in one or both of the Flexible Spending Accounts, that I must file for reimbursement from those accounts by October 15, 2009 in order to avoid losing my contributions, and that my decision to deposit funds in the Spending Accounts is binding through June 30, 2009 and can only be modified if there is a qualifying change in family status.

I understand that the Flexible Benefits Program offered by the State is subject to modifications and changes and that the benefits I have chosen on this enrollment form are only in effect for July 2008-June 2009. The State of Maryland reserves the right to modify any of the benefits provided and gives no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond June 30, 2009. **I certify that neither I nor my covered dependents are covered under another State of Maryland employee's or retiree's membership for any type of duplicate coverage.**

I CERTIFY THAT I AND ANY DEPENDENTS LISTED FOR COVERAGE ARE ELIGIBLE FOR COVERAGE. I UNDERSTAND THAT ENROLLMENT IN BENEFITS TO WHICH I OR MY DEPENDENTS ARE NOT ENTITLED IS CONSIDERED FRAUD. **IN ALL CASES I AM RESPONSIBLE FOR THE ACCURACY OF MY BENEFITS, COVERAGE LEVELS AND DEDUCTIONS.** I FURTHER UNDERSTAND THAT IF I WILLFULLY MISREPRESENT THE ELIGIBILITY OF MYSELF OR MY DEPENDENTS ON MY HEALTH BENEFITS APPLICATION, OR FAIL TO TAKE THE NECESSARY ACTION TO REMOVE INELIGIBLE DEPENDENTS, OR IN ANY WAY OBTAIN BENEFITS TO WHICH I AM NOT ENTITLED, MY BENEFITS WILL BE CANCELED. I MAY BE REQUIRED TO REPAY ANY CLAIMS AND INSURANCE PREMIUMS WHICH HAVE BEEN PAID INAPPROPRIATELY, I MAY FACE CHARGES FOR DISMISSAL FROM STATE SERVICE, AND I MAY FACE CRIMINAL INVESTIGATION AND PROSECUTION.

NOTE: If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a member service representative before signing this application.

Is there any other health insurance coverage in which you, your spouse or any of your dependents are enrolled? ○ Yes ○ No

Specify who is covered, name of Insurance Company and Policy Number:_____

I certify that I have discussed a Retroactive Adjustment with my Agency Benefits Coordinator.

X _____ _____/_____/_____ (_____) _____ (_____) _____

Employee Signature | Date | Work Phone Number (Ext.) | Your Home/Cell Phone Number

Agency Signature - *Agency Must Sign Here* FORMS WILL NOT BE PROCESSED WITHOUT AN AGENCY SIGNATURE

I hereby certify that the person applying for enrollment is employed by the Agency. I certify that I have discussed a Retroactive Adjustment with the employee and have reviewed the form and accompanying documents for accuracy.

X _____ _____/_____/_____ (_____) _____ _____

Agency Benefits Coordinator | Date | Work Phone Number (Ext.) | Department

UMCES HUMAN RESOURCES DEPARTMENT

State Vehicle Policy

By signing below, I acknowledge that I have received and reviewed and reviewed the policy regarding the rules for drivers of UMCES vehicles.

I am aware that willful disregard of these rules will be considered just cause for disciplinary action.

EMPLOYEE NAME ***SOCIAL SECURITY NUMBER***

DRIVER LICENSE NUMBER ***STATE*** ***EXPIRATION DATE***

DATE OF BIRTH ***JOB TITLE***

STATUS: ☐ ***REGULAR EMPLOYMENT (salaried)***
☐ ***HOURLY***
☐ ***SUMMER EMPLOYEE ONLY***
☐ ***VOLUNTEER***

UMCES Site/Location:

SIGNATURE

EMPLOYEE ***DATE***

UMCES HUMAN RESOURCES DEPARTMENT

DATE:

Substance Abuse Policy

Maryland State Executive Order 01.01.1991.16 implementation requires that:

AAll State employees acknowledge receipt of a copy of the State of Maryland Substance Abuse Policy.@

Your signature acknowledges receipt of the Policy.

By signing below, I acknowledge that I have received and reviewed a copy of Maryland State Executive Order 01.01.1991.16 regarding the State of Maryland Substance Abuse Policy.

LOCATION:

SIGNATURE

EMPLOYEE ***DATE***

Application for Employment

University of Maryland
CENTER FOR ENVIRONMENTAL SCIENCE

THE CENTER FOR ENVIRONMENTAL SCIENCE ACTIVELY SUBSCRIBES TO A POLICY OF EQUAL EMPLOYMENT OPPORTUNITY AND WILL NOT DISCRIMINATE AGAINST ANY EMPLOYEE OR APPLICANT BECAUSE OF RACE, SEX, AGE, COLOR, PHYSICAL OR MENTAL DISABILITY, MARITAL STATUS, RELIGION, NATIONAL ORIGIN, OR POLITICAL AFFILIATION.

PLEASE PRINT OR TYPE (USE BLACK IN K ONLY)			**DO NOT WRITE IN THIS SPACE** POSTIONS QUALIFIED FOR: 1._____ 2._____ 3._____ 4._____ 5._____ **TYPING SPEED** _____ **SHORT HAND SPEED** _____ **DATE** _____ **CREDENTIALS VERIFIED** _____
LAST NAME	FIRST	MIDDLE	
ADDRESS		APT	
CITY	STATE	ZIIP CODE	
HOME PHONE	BUSINESS PHONE	SOCIAL SECURITY NUMBER	
IIF NOT A U.S. CITIZEN, INDICATE VISA CLASS AND NUMBER	IIF YOU ARE CURRENTLY EMPLOYED, MAY WE CONTACT YOUR EMPLOYER? YES_____ NO_____ YOUR PREVIOUS EMPLOYERS? YES_____ NO_____	HOW REFERRED TO THE UNIVERSITY	

EMPLOYMENT RECORD

BEGIN WITH CURRENT OR PORE RECENT POSITION AND WORK BACKWARD. PLEASE COMPLETE IN DETAIL AND EXPLAIN ANY LAPSE FOR WHICH TIME IS NOT ACCOUNTED. INCLUDE PART-TIME AND VOLUNTEER EXPERIENCE.

EMPLOYER ADDRESS TELEPHONE	**EMPLOYED** FROM TO ____/____/____ ____/____/____	YOUR DUTIES AND RESPONSIBILITIES
YOUR TITLE NAME AND TITLE OF SUPERVISOR REASON FOR LEAVING	BASE SALARY $_____ FIRST $_____ LAST	DID YOU SUPERVISE ANYONE? YES NO
EMPLOYER ADDRESS TELEPHONE	EMPLOYED FROM TO ____/____/____ ____/____/____	YOUR DUTIES AND RESPONSIBILITES
YOUR TITLE NAME AND TITLE OF SUPERVISOR REASON FOR LEAVING	BASE SALARY $_____ FIRST $_____ LAST	DID YOU SUPERVISE ANYONE? YES NO
EMPLOYER ADDRESS TELEPHONE	EMPLOYED FROM TO / / / /	YOUR DUTIES AND RESPONSIBILITES
YOUR TITLE NAME AND TITLE OF SUPERVISOR REASON FOR LEAVING	BASE SALARY $_____ FIRST $_____ LAST	DID YOU SUPERVISE ANYONE? YES NO
EMPLOYER ADDRESS TELEPHONE	EMPLOYED FROM TO ____/____/____ ____/____/____	YOUR DUTIES AND RESPONSIBILITES
YOUR TITLE NAME AND TITLE OF SUPERVISOR REASON FOR LEAVING	BASE SALARY $_____ FIRST $_____ LAST	DID YOU SUPERVISE ANYONE? YES NO

SCHOOLS	NAME & ADDRESS OF SCHOOL	DATES	INDICATE HIGHEST LEVEL COMPLETED	MAJOR OR TYPE OF PROGRAM	TYPE OF DEGREE OR CERTIFICATE AND DATE
HIGH SCHOOL OR GRADE SCHOOL					
COLLEGE					
GRADUATE SCHOOL					
VOCATIONAL OR BUSINESS SCHOOL					

SPECIAL QUALIFICATIONS AND SKILLS (OFFICE MACHINES OPERATED, INCLUDING EQUIPMENT, FOREIGN LANGUAGES SPOKEN, ETC.)			
U.S MILITARY SERVICE	TYPE OF DISCHARGE	DATE OF ENTRANCE	DATE OF DISCHARGE
DESCRIBE YOUR DUTIES IN THE MILITARY			

If your answer is yes to any of the following questions, please explain in the box to the right.	
a. Have you ever worked for the University System of Maryland or the State of Maryland? _____Yes _____No	
b. Have you ever been convicted in court for Other than a misdemeanor or a minor traffic Violation? _____Yes _____No	
c. Are you under 18 years of age? _____Yes _____No	

Additional Comments (For additional information you wish to submit)

_____

_____

_____

_____

I certify that all information on this application is accurate and recognize it is subject to verification and that my employment and/or continuance thereof is contingent upon its accuracy. I understand that an offer of employment, if made, may be contingent upon the satisfactory result of a post-offer medical examination or medical inquiry. I understand that employment by UMCES is subject to the policies and practices adopted by or applicable to the University of Maryland System or UMCES.

Signature of Applicant _____ Date _____

_____**Do Not Write Below this Line** _____

Interview's Comments

Date

_____

_____

_____

University of Maryland
CENTER FOR ENVIRONMENTAL SCIENCE

CENTER ADMINISTRATION

Post Office Box 775
Cambridge, MD 21613-0075
(410) 228-9250
Fax: (410) 228-3843
http://www.umces.edu

ID Card Information

Name: _____

SSN: _____

Date of Birth: _____

Select One: ☐ Faculty ☐ Staff ☐ Student

Signature