



NEW HIRE CHECKLIST – POLICE DEPARTMENT (FULL-TIME)

Welcome to the Town of West Seneca! Your appointment is pending Town Board approval and meeting required contingencies with the Town of West Seneca and Erie County.

As part of your onboarding process, we will need you to complete ALL REQUIRED DOCUMENTS in the new hire packet.

Below is a list of the documents included in the new hire packet. **ALL ARE REQUIRED** unless otherwise noted as optional. Please review your packet before submitting to Human Resources. Use the Document List below to check for completed form. Also, return the new hire paperwork in the order of the Document List below.

DOCUMENT NAME	CHECK WHEN COMPLETED
APPLICATION	_____
ECO CHANGE FORM	_____
EMERGENCY CONTACT FORM	_____
W4	_____
IT2104	_____
W-9	_____
I-9*	_____
EEO1	_____
DIRECT DEPOSIT FORM	_____
PFRS APPLICATION	_____
CODE OF ETHICS AND ACKNOWLEDGEMENT	_____
HIGHMARK OF WNY ENROLLMENT FORM (HEALTH)**	_____
NYSDCP ENROLLMENT FORM (OPTIONAL)	Provided by HR upon Request

**** Be sure to review page 3 of the Form I-9 and bring original acceptable documentation to your onboarding session.**

**** If you will not be enrolling in health care coverage, you will need to complete the Waiver of Benefits on the Highmark of WNY Enrollment Form.**

For your records:

BENEFIT EXPLANATION – PBA

POS201 PLAN INFORMATION

TRA901 PLAN INFORMATION

POS226D (GOLD) PLAN INFORMATION



TOWN OF
WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

Upon completion of all required documents, your new hire packet will be submitted to the Finance Department for set up in the payroll and time and attendance system. Please be aware that incomplete paperwork may delay your approved start date.

If you have any questions, please feel free to reach out to me via email at lscibetta@ebchcm.com or phone at (716) 482-7582. I look forward to working together to support the Town of West Seneca.

Lisa Scibetta

HR Advisor to the Town of West Seneca



APPLICATION FOR EMPLOYMENT

All applicants are considered for all positions without regard to race, color, citizenship status, religion, gender (including pregnancy), national origin, ancestry, age, physical or mental disability, domestic victim status, sexual orientation, marital status, military status, or any other characteristic protected by law, ordinance, or regulation. Those applicants requiring accommodation to complete the application and/or interview process should contact Human Resources. Please print.

Position(s) Applied for		Date of Application	
Print Name (Last, First, & Middle)		Other Names Used	
Street Address		City	State Zip Code
Home Phone Number	Cell Phone Number	Email	

Have you ever worked for the Town of West Seneca before?.....☐ Yes ☐ No

If yes, please give dates and position: _____

DEPARTMENT DESIRED

Please mark next to any departments for which you are applying. For certain positions, there are specific certifications that are required.

____ Highway ____ Buildings & Grounds ____ Engineering ____ Police ____ Clerk's Office
____ Senior Center ____ Assessor's Office ____ Recreation ____ Code Enforcement

Position Applying For: _____ Are you at least 16 years old? ☐ Yes ☐ No

EMPLOYMENT EXPERIENCE

Please list the names of your present or previous employers in chronological order with present or most recent employer listed first. Be sure to account for all periods of time. If self-employed, please provide the name of the firm. [Add additional page if necessary]

Company Name & Address	Position	Dates From/To	Reason for Leaving
1.) _____ _____	_____	_____ (mm/yy-mm/yy)	_____
2.) _____ _____	_____	_____ (mm/yy-mm/yy)	_____

Have you ever been involuntarily terminated or asked to resign from any job?.....☐ Yes ☐ No

If yes, please explain:

Please explain any gaps in your employment history:

--

Please list any other experience, job related skills, additional languages, certifications and/or specialized training or other qualifications that you believe should be considered in evaluating your application for employment.

--

EDUCATION

Please describe your educational background in the table provided below:

	School Name	Years Completed	Diploma/ Degree (Yes/No)	Course of Study/Major
High School				
College/ University				
Graduate/ Professional School				
Trade School				
Other				
Military Service				

PROFESSIONAL AND PERSONAL REFERENCES

Please list one to two professional/personal references of individuals who are **not** related to you:

Name and Title	Relationship and Years Acquainted	Phone Number or Email

GENERAL INFORMATION

1. On what date are you available to begin work? _____

2. Days/Hours available to work:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

3. Are you available to work? ☐ Full-time ☐ Part-time ☐ Seasonal

If seasonal, what date do you need to end work? _____

4. Minimum salary desired.....Per Hour \$_____ Per Month \$_____

5. If hired, would you have a reliable means of transportation to and from work?.....☐ Yes ☐ No

- a. Do you have a valid NY driver license?..... ☐ Yes ☐ No
6. Are you at least 18 years old?.....☐ Yes ☐ No
- a. Note: If under 18, hire is subject to verification that you are of minimum legal age.
7. If hired, can you present evidence of your identity and legal right to work in this country?.....☐ Yes ☐ No
8. Are you able to perform the essential job functions of the job for which you are applying with or without reasonable accommodation?.....☐ Yes ☐ No
- a. Note: We comply with the ADA and consider reasonable accommodation measures that may be necessary for qualified applicants/employees to perform essential job functions.

Applicant Statement and Agreement

Please read and initial each paragraph below. If there is anything that you do not understand, please ask.

_____ I hereby authorize the Town to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the prior employers and references I have listed to disclose to the Town any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. In addition, I hereby release the Town, my former employers and all other persons, corporations, partnerships and associations from any and all claims, demands or liabilities arising out of or in any way related to such investigation or disclosure. My employment is contingent upon acceptable results of a drug screen, background check, and driving history. My employment is also contingent upon providing to the Town a receipt of a medical physical.

_____ In the event of my employment with the Town, I understand that I am required to comply with all rules and regulations of the Town.

_____ If hired, unless subject to any other agreement, I understand and agree that my employment with the Town is at-will, and that neither I, nor the Town is required to continue the employment relationship for any specific term. I further understand that the Town or I may terminate the employment relationship at any time, with or without cause, and with or without notice. I understand that the at-will status of my employment cannot be amended, modified, or altered in any way by any oral modifications.

_____ I hereby certify that the answers given by me are true and correct to the best of my knowledge. I further certify that I, the undersigned applicant, have personally completed this application. I understand that any omission or misstatement of material fact on this application or on any document used to secure employment shall be grounds for rejection of this application or for immediate discharge if I am employed, regardless of the time elapsed before discovery.

_____ I understand that if I am selected for hire, it will be necessary for me to provide satisfactory evidence of my identity and legal authority to work in the United States, and that federal immigration laws require me to complete a Form I-9 in this regard.

_____ I understand that if any term, provision, or portion of this Agreement is declared void or unenforceable, it shall be severed and the remainder of this Agreement shall be enforceable.

MY SIGNATURE BELOW ATTESTS TO THE FACT THAT I HAVE READ, UNDERSTAND, AND AGREE TO ALL OF THE ABOVE TERMS.

Signature _____

Date _____

Employee Change Form Information

For Supplementary Payroll Certification Report of Personnel Change to Erie County

Effective Date:

Employee Data			
Social Security Number:		Retirement Number:	
Name (Last, First):		Veteran Exemption (Y/N):	
Street Address:		Dates of Service:	From: To:
City/Town:		Volunteer Firemen: (Y/N)	
Zip Code:		Dates of Service:	From: To:

Title – Classification – Salary Information			
Are you currently employed by the Town of West Seneca? (Y/N)			
If “yes”, complete below. If “no”, leave blank:		Must be completed:	
Current Title:		New Title:	
Current Salary:		New Salary:	
Type (Check One):	Meeting	Type (Check One):	Meeting
	Daily		Daily
	Hourly		Hourly
	Weekly		Weekly
	BiWeekly		BiWeekly
	Quarterly		Quarterly
	Annually		Annually
Classification: (Check One)	Competitive	Classification: (Check One)	Competitive
	Non-Competitive		Non-Competitive
	Labor		Labor
	Exempt		Exempt
	Unclassified		Unclassified

Employee Type – For Temporary Appointment, WRITE IN END DATE					
Full Time Permanent			Part Time Temporary Seasonal		
Full Time Provisional			Regular Part Time Permanent		
Full Time Temporary			Regular Part Time Temporary		
Part Time Regular Permanent			Full Time Contingent Permanent		
Part Time Temporary			Part Time Provisional		
Part Time Permanent			Regular Part Time Provisional		



Emergency Contact Sheet

Name: _____

In the event of an emergency situation, please contact the following individual(s):

	Primary Contact:	Secondary Contact:
Contact Name:	_____	_____
Relationship:	_____	_____
Daytime Phone Number:	_____	_____
Home Phone Number:	_____	_____
Cellular Phone Number:	_____	_____

*****DON'T FORGET HEALTH INSURANCE & RETIREMENT SYSTEM*****

If you have health insurance with the Town and/or are a member of the NYS Retirement System, please call the following numbers for a change of address.

Blue Cross Blue Shield: 1-800-544-2583

NYS Retirement System: 1-866-805-0990

In the event of an emergency, each employee's emergency contact information may be accessed confidentially by Department Heads. If you do not wish to have your emergency contact information shared with the Department Heads, please initial here: _____

Employee Signature: _____ Date: _____

Should any of the above information change, please submit revisions to a member of the Human Resources Department.

Payroll _____

Benefits _____

HR _____

Employee's Withholding Certificate

OMB No. 1545-0074

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.****2023****Step 1:
Enter
Personal
Information**

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

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

**Step 2:
Multiple Jobs
or Spouse
Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

- (a) Reserved for future use.
- (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**
- (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate ☐

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

Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):		
	Multiply the number of qualifying children under age 17 by \$2,000 \$ _____		
	Multiply the number of other dependents by \$500 \$ _____		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$ _____

**Step 5:
Sign
Here**

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

Employee's signature (This form is not valid unless you sign it.)

Date

**Employers
Only**

Employer's name and address	First date of employment	Employer identification number (EIN)
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General Instructions

Section references are to the Internal Revenue Code.

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2023 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2024.

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

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

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

If you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



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

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

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2023 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.



Department of Taxation and Finance

Employee's Withholding Allowance Certificate

New York State • New York City • Yonkers

IT-2104

First name and middle initial		Last name		Your Social Security number	
Permanent home address (number and street or rural route)			Apartment number		Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/>
City, village, or post office			State	ZIP code	Married, but withhold at higher single rate <input type="checkbox"/>
Note: If married but legally separated, mark an X in the <i>Single or Head of household</i> box.					
Are you a resident of New York City? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Are you a resident of Yonkers? Yes <input type="checkbox"/> No <input type="checkbox"/>					
Before making any entries, see the Note below, and if applicable, complete the worksheet in the instructions.					
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 19, if using worksheet)				1	
2 Total number of allowances for New York City (from line 31, if using worksheet)				2	
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.					
3 New York State amount				3	
4 New York City amount				4	
5 Yonkers amount				5	

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee's signature	Date
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Employee: Give this form to your employer and keep a copy for your records. Remember to review this form once a year and update it if needed.**Note:** Single taxpayers with one job and zero dependents, enter **1** on lines 1 and 2 (if applicable). Married taxpayers with or without dependents, heads of household or taxpayers that expect to itemize deductions or claim tax credits, or both, complete the worksheet in the instructions. Visit www.tax.ny.gov (search: *IT-2104-I*) or scan the QR code below.**Employer: Keep this certificate with your records.**If any of the following apply, mark an **X** in each corresponding box, complete the additional information requested, and send an additional copy of this form to New York State. See **Employer** in the instructions. Visit www.tax.nys.gov (search: *IT-2104-I*) or scan the QR code below.A Employee claimed more than 14 exemption allowances for New York State A ☐B Employee is a new hire or a rehire ... B ☐ First date employee performed services for pay (mm-dd-yyyy) (see Box B instructions): You may report new hire information online instead of mailing the form to New York State. Visit www.nynewhire.com.**Note:** Employers **must** report individuals under an **independent contractor arrangement** with contracts in excess of \$2,500 using the online reporting website above, **not** Form IT-2104.Are dependent health insurance benefits available for this employee? Yes ☐ No ☐If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the New York State Tax Department.)	Employer identification number
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Scan here

<https://www.tax.ny.gov/r/it2104i-2023>

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ►	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <small>(Applies to accounts maintained outside the U.S.)</small>
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
	6 City, state, and ZIP code	
	7 List account number(s) here (optional)	

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number								
				-				
or								
Employer identification number								
				-				

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ►	Date ►
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.



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

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
		<input type="checkbox"/> 1. A citizen of the United States					
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)					
		If you check Item Number 4. , enter one of these:					
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance	
Signature of Employee					Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C	
Document Title 1						
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 2 (if any)		Additional Information				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 3 (if any)						
Issuing Authority		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Document Number (if any)						
Expiration Date (if any)						
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):	
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

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

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

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
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <p style="text-align: center;">For persons under age 18 who are unable to present a document listed above:</p> <ol style="list-style-type: none"> 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p>For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p>The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.				
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.		Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
--	--	---

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

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

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)		Middle Initial (<i>if any</i>)
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code



Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name (<i>Family Name</i>) from Section 1 .	First Name (<i>Given Name</i>) from Section 1 .	Middle initial (if any) from Section 1 .
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the [Handbook for Employers: Guidance for Completing Form I-9 \(M-274\)](#)

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (<i>if applicable</i>)	New Name (<i>if applicable</i>)		
Date (<i>mm/dd/yyyy</i>)	Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (<i>mm/dd/yyyy</i>)	
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 documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (<i>mm/dd/yyyy</i>)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.



EQUAL EMPLOYMENT OPPORTUNITY VOLUNTARY SELF-IDENTIFICATION
APPLICANT OR EMPLOYEE SURVEY

Name: _____

Position (or position applying for): _____

Date: _____

Our company is an equal opportunity employer and does not discriminate in firing or employment on the basis of race, color, religion, sex, national origin, age, disability or any other basis prohibited by federal, state or local law. No question on this form is intended to secure information to be used for such discrimination.

The company is required by federal regulation to report information as requested below. Your contribution of this information is completely *voluntary* and refusal to complete this form will not affect any hiring or employment decisions. The information you provide is strictly confidential and will be maintained separate from your personnel file. You may inform us of your desire to benefit under the program at this time and/or any time in the future.

PLEASE CHECK ONE: ☐ Male ☐ Female

INDICATE THE APPROPRIATE RACE/ETHNIC GROUP:

☐ **White** (not Hispanic or Latino) – having origins in any of the original peoples of Europe, the Middle East or North Africa

☐ **Hispanic or Latino** – of Cuban, Mexican, Puerto Rican, South or Central American descent, or other Spanish culture or origin regardless of race

☐ **Native Hawaiian or other Pacific Islander** (not Hispanic or Latino) – having origins in any of the peoples of Hawaii, Guam, Samoa or other Pacific Islands

☐ **Black or African-American** (not Hispanic or Latino) – having origins in any of the black racial groups of Africa

☐ **American Indian or Alaskan Native** (not Hispanic or Latino) – having origins in the original peoples of North or South America (including Central America), and maintaining tribal affiliations or community involvement

☐ **Asian** (not Hispanic or Latino) – having origins in the Far East, Southeast Asia or the Indian Subcontinent, including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam

☐ **Two or more races** (not Hispanic or Latino) – anyone who identifies with more than one of the above five races

☐ **Other**

Payroll _____

Benefits _____

HR _____



DIRECT DEPOSIT AUTHORIZATION AGREEMENT

Last Name

First Name

Last 4 SSN

Please complete form even if you have had Direct Deposit in the past.

Bank Name	Transit/ ABA Number	Type of Account	Amount or Percent	Account Number
		[] Checking [] Savings		
		[] Checking [] Savings		
		[] Checking [] Savings		
		[] Checking [] Savings		

☐ I have attached a voided personalized check (checking accounts) or deposit slip (savings accounts) for each account specified. (This request will not be processed without the accompanying documentation.)

I hereby authorize the Town of West Seneca to directly deposit any salary or wages due to me, less any mandatory or authorized withholdings or deductions in the bank account(s) listed above in the percentages specified. (If two or more accounts are designated, deposits are to be made in whole percentages of pay to total 100%.)

The Town will credit my account(s) the amount of my payroll check on payday. Deposits are normally available the morning of pay date however each bank posts funds to accounts at different times daily, and the Town of West Seneca has no control over my bank's posting. Also, I hereby grant the Town of West Seneca the right to correct any such electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

I authorize my financial institution to accept direct deposits to my account upon receipt and without advice to me. It is my responsibility to verify deposits on a per pay date basis before writing checks against these funds. I understand that the Town of West Seneca is not responsible for bank errors or bank fees. Banking services are provided in accordance with the limitations and restrictions of the Automated Clearing House Association.

This authorization is to remain in force until the Town of West Seneca has received written authorization from me of its termination or change. I understand that if my account has closed, my financial institution cannot accept a deposit on my behalf. If this occurs, my employer will not be able to process any further direct deposits without further written authorization from me. IN ORDER TO TERMINATE OR REVOKE THIS AUTHORIZATION, I MUST NOTIFY MY EMPLOYER IN WRITING AT LEAST TWO WEEKS PRIOR TO THE TERMINATION.

Signature: _____ Date: _____

Please allow 2-4 weeks for your direct deposit to begin.

Please verify with your bank that your first direct deposit has been processed correctly.



New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

Fax Number: (518)486-4382

For questions concerning Member

Enrollment call: (518) 474-3081

NYSLRS ID

--	--	--	--	--	--	--	--	--	--

Received Date

--	--	--	--	--	--	--	--	--	--

Social Security Number *

--	--	--	--	--	--	--	--	--	--

Police and Fire Membership Registration

PF 5022

(Rev. 11/22)

Plan	Tier	Rate	Date of Membership (mm/dd/yyyy)		

Registration Number							

Part 1: Employee – Read information provided on page 2.

Employee's Last Name:		First Name:		Middle Initial:
Employee's Address:	Apt	City	State	Zip Code
Former Name: (if applicable)		Date of Birth (mm/dd/yyyy)		Sex
				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X
Are you receiving or about to receive a pension from a New York State or New York City public retirement system? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate name of system: _____				
Are you inactive or withdrawn from a New York State or New York City public retirement system? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate name of system: _____				
(NYS Teachers', NYS Employees', NYS Police and Fire, NYC Police Pension Fund, NYC Fire Pension Fund, NYC Board of Education, NYC Teachers', NYC Employees')				

Part 2: Employer – See page 2 for additional information and instructions regarding the completion of this form.

Employer's Name:				Employer's Telephone:						
Employer's Address:				Employer's Fax Number:						
Job Code [1]		Employee Classification				<input type="checkbox"/> Regular [2]		<input type="checkbox"/> Full Time		
		<input type="checkbox"/> 12 Month <input type="checkbox"/> 12 Month Provisional <input type="checkbox"/> Seasonal				<input type="checkbox"/> Temporary		<input type="checkbox"/> Part Time		
Hire Date [3]			Standard Workday [4]		Location Code			For State Agency Use Only – Agency Code		
Month	Day	Year								

Frequency of Payment

<input type="checkbox"/> Weekly	<input type="checkbox"/> Bi-Weekly	<input type="checkbox"/> Semi- Monthly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semi- Annually	<input type="checkbox"/> Annually	<input type="checkbox"/> Other- Please Specify _____
---------------------------------	------------------------------------	--	----------------------------------	------------------------------------	---	-----------------------------------	--

Projected Annualized Wage [5]

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Tier 6 requires employers to determine the Annualized Wage for individuals who work part-time, seasonal or on an hourly, daily, or unit of work basis. We ask that you use this calculation for all other tiers as well. See Page 2 for examples.

Part 1-Employee Instructions

Warning: If you are receiving or are about to receive a pension from another New York State or New York City public retirement system, contact us directly before enrolling in NYSLRS. Enrollment may result in suspension of your pension benefit. NYSLRS retirees should contact us directly before enrollment to discuss working after retirement and possible restoration of membership.

Membership Information:

- If you are currently an active or vested member of any other public retirement system in New York State, you should contact that system concerning the advantages of transferring your membership to this System. Failure to contact that system could cause loss of the privilege of transferring membership and may affect contribution cessation dates.
- **If you were previously a member of any public retirement system in New York State, and your membership was terminated or withdrawn, you may be eligible for a reinstatement of that membership. It is highly recommended that if you have a prior Tier 1 or 2 membership in any New York public retirement system that you complete the Tier Reinstatement application, RS5506 and include it with your membership registration application.**
- You may also be eligible to receive credit for public service earned with a participating employer before your current date of membership. This additional service may impact your future benefits.
- You are covered by the Death Benefit allowed by law for your tier and plan status. If you have not already done so, complete an RS5127 Designation of Beneficiary with Contingent Beneficiaries form to designate beneficiary(ies) to receive an Ordinary Death Benefit. If there is no RS5127 Designation of Beneficiary with Contingent Beneficiaries on file with this System, your Ordinary Death Benefit will become payable to your estate.

Part 2 – Employer Instructions

Field Explanation and information:

- [1] Job Code – As the employer you will need to reference our job code list at www.osc.state.ny.us/retire/retirement_online/job-codes.php to determine which job code is applicable to the employee's job title.
- [2] Regular is the same as Permanent or Probationary. Temporary is anything other than Regular
- [3] Hire Date – When enrolling someone through Employer Retirement Online, you **must** populate the Hire Date field and the Date of Full-Time Permanent Appointment field with the same date. This date **must** be the Hire Date in order to establish the correct Date of Membership.
- [4] Standard Workday – A standard workday (hrs/day) applies to all tiers. The minimum number of hours that can be established for a standard workday is six, while the maximum is eight. A standard workday is the denominator to be used for the days worked calculation; it is not necessarily the number of hours the person actually works. For example, if a bus driver works four hours a day, you must establish a standard workday between six and eight hours as the denominator for their days worked calculation. When entering the information on Employer Retirement Online, you will need to select "Daily" for the work period and then enter the standard workday in the standard hours field.
- [5] Projected Annualized Wage – Examples of Tier 6 annual wage for individuals paid at an Hourly, Daily or Unit of Work basis of compensation.

Hourly Employees 12 month Employee: \$ _____ X _____ X 260 = \$ _____ Hourly Standard Days Annual Rate Workday Worked Wage 10 month Employee: \$ _____ X _____ X 180 = \$ _____ Hourly Standard Days Annual Rate Workday Worked Wage	Daily Employees 12 month Employee: \$ _____ X 260 = \$ _____ Daily Days Annual Rate Worked Wage 10 month Employee: \$ _____ X 180 = \$ _____ Daily Days Annual Rate Worked Wage
Unit of Work Employees \$ _____ X _____ = _____ Unit Rate # of Events** Annual Wage **Estimated or Actual	Unit of Work Employee Example: Paid \$50 per Meeting \$ 50 X 12 Meetings = \$600 Unit Rate # of Events*** Annual Wage ***An estimate of the number of events is acceptable

Note: Any questions regarding annualized wage, please contact the Retirement System.

*Social Security Disclosure Requirement

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of your Social Security account number is mandatory pursuant to Sections 11, and 34 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Personal Privacy Protection Law

The Retirement System is required by law to maintain records to determine eligibility for and calculate benefits. Failure to provide information may interfere with the timely payment of benefits. The System may be required to provide certain information to participating employers. The official responsible for record maintenance is the Director of Member and Employer Services, NYS and Local Retirement System, Albany, NY 12244; call toll-free at 1-866-805-0990 or 518-474-7736 in the Albany Area.

Chapter 13. Ethics, Code of

[HISTORY: Adopted by the Town Board of the Town of West Seneca 12-16-2019 by L.L. No. 5-2019.¹¹¹ Amendments noted where applicable.]

[1] *Editor's Note: This chapter also superseded former Ch. 13, Ethics, Code of, adopted 12-7-2009 by L.L. No. 4-2009.*

§ 13-1. Legislative intent.

The proper operation of Town government requires that its officers and employees be independent, impartial and responsible to the people; that government decisions and policy be made in the proper channels of the governmental structure; that public office not be used for personal gain; that public officers and employees observe in their official acts the highest standards of ethics and discharge faithfully the duties of their public office regardless of personal consideration; and that the public have confidence in the integrity of its government and the officers and employees thereof. It is the policy of the Town of West Seneca and the purpose of this chapter to establish standards and guidelines for ethical conduct of officers and employees. Though assurance of such conduct will continue to rest primarily on personal integrity and community vigilance, the establishment of standards is another step toward providing the highest caliber of public administration for the Town and ensuring that government decisions are arrived at impartially and free of conflict of interests and thereby increasing confidence in public officials. It is also the purpose of this chapter to protect officials and employees from unwarranted assaults on their integrity by separating real conflict from the inconsequential, recognizing that for local government to attract and hold competent administrators, public service must not require a complete divesting of all proprietary interests. In recognition of these goals, there is hereby established a Code of Ethics for all officers and for all employees of the Town of West Seneca, hereinafter referred to as the "Town." In the event of any conflict between the provisions of this Code and provisions of Article 18 of the General Municipal Law, the latter shall control. This chapter shall be enforceable upon all Town officials, officers and employees. No acknowledgement, service or acceptance of this chapter shall be necessary for enforcement of its provisions.

§ 13-2. Definitions and word usage.

A. Definitions. As used in this chapter, the following terms shall have the meanings indicated:

AGENCY

Any Town department, division, board, committee, or bureau, including the Town Board or any successor thereto.

APPEAR and APPEAR BEFORE

Communicating in any form, including without limitation, personally, by letter, electronic communication, telephone or by any other device.

CONFIDENTIAL INFORMATION

The same meaning as defined in the New York State Public Officer's Law¹¹¹ as well as any information discussed and/or revealed at an executive session of a Town Board meeting.

CONFLICT OF INTEREST

Any action or omission which is in conflict or gives or may reasonably give the appearance of conflict with the performance of official Town business or government.

CUSTOMER or CLIENT

Any entity or person to whom an official, officer or employee of the Town of West Seneca or his or her outside employer or business has supplied goods or services during the previous calendar year having, in the aggregate, a value greater than \$2,000.

FINANCIAL BENEFIT

Any money, service, license, permit, contract, authorization, loan, travel, entertainment, hospitality, gratuity or other compensation of anything of value, or any promise thereof.

GOOD FAITH

Information concerning potential wrongdoing is disclosed in good faith when the individual making the disclosure reasonably believes such information to be true and reasonably believes that it constitutes potential wrongdoing.

HOUSEHOLD

All persons living in a single residence, whether related or not.

INTEREST

Deemed to include the affairs of the official, officer or employee or their spouse, minor children and dependents, firm, partnership or association in which such official, officer or employee is a member or employee; a corporation in which such official officer or employee is an officer director, or employee; and a corporation of which any stock is owned or controlled directly by the official, officer or employee.

PERSONNEL ACTION

Any action affecting compensation, appointment, promotion, transfer, assignment, reassignment, reinstatement or evaluation of performance.

RECUSE

The act of abstaining from participation or influencing in an official action due to a conflict of interest.

RELATIVE

A spouse, parent, grandparent, stepparent, sibling, step-sibling, sibling's spouse, child, grandchild, stepchild, uncle, aunt, nephew, niece or household member of a Town official, officer or employee and individuals having any of these relationships to the spouse of the Town official, officer or employee.

TOWN EMPLOYEE

All board members, officers and staff employed by the Town, whether employed full-time or part-time, employed pursuant to a contract, employed temporarily or employees who are on probation, paid or unpaid.

WHISTLEBLOWER

Any Town employee (as defined herein) who in good faith discloses information concerning wrongdoing by another Town employee or concerning the business of the Town itself.

WRONGDOING

Any alleged corruption, fraud, criminal or unethical activity, misconduct, waste, conflict of interest, intentional reporting of false or misleading information or abuse of authority engaged in by a Town employee (as defined herein) that relates to the Town.

[1] *Editor's Note: See McKinney's Public Officers Law § 1 et seq.*

- B. Word usage. The use of the masculine gender shall include the feminine where applicable.

§ 13-3. Standards of conduct.

Every official, officer and employee of the Town of West Seneca shall be subject to and abide by the following standards of conduct:

- A. No Town official, officer or employee shall use his or her official position or office to take or fail to take any action in a manner which he or she knows or has reason to know may result in a financial benefit or interest for any of the following persons or entities:
- (1) The Town official, officer or employee;
 - (2) His or her outside employer or business;
 - (3) A member of his household;
 - (4) A customer or client; or
 - (5) A relative.
- B. No Town official, officer or employee shall have any interest, financial or otherwise, direct or indirect, or engage in any business or transaction or professional activity or incur any obligation of any nature that is in conflict with, or might reasonably tend to conflict with, the proper discharge of his duties in the public interest. Any officer or employee who has a direct or indirect financial or other private interest in any matter before any board of the Town shall publicly disclose in writing on the official record of such board the nature and extent of such interest prior to participating in the discussion or before making a recommendation or giving an opinion to such board on such matter.
- C. No Town official, officer or employee shall represent private interests before any board, department, office or agency of the Town, nor represent private interests in any action or proceeding against the interests of the Town or in any litigation to which the Town is a party. The preceding sentence shall not preclude any such officers or employees from appearing in the performance of public or civic obligations or on their own behalf with respect to matters of a personal nature. All appearing parties before any board of the Town shall make a disclosure as provided under § 809 of Article 18 of the General Municipal Law. Every application, petition or request submitted for a variance, change of zoning, site plan approval or waiver, license or permit pursuant to the provisions of any ordinance, local law, rule or regulation constituting the zoning and planning regulations of the Town in which a Town officer or employee has an interest as defined in this chapter shall state the name, residence and the nature and extent of the interest of any officer or employee of the Town, in the person, partnership or association making such application, petition or request.
- D. A Town Board member, official, officer or employee shall promptly recuse himself or herself from acting on a matter before the Town when acting on the matter or failing to act on the matter may provide a financial benefit to the persons or entities listed in § 13-3A above. A Town Board member shall promptly recuse himself or herself from voting on the appointment, hiring, or other matter involving a person or entity described in § 13-3A above.
- E. No Town official, officer or employee, whether paid or unpaid, shall directly or indirectly solicit, accept or receive any gift, whether in the form of money, services, loan, travel, entertainment, hospitality, material goods, things, or promise of any other form, under circumstances in which it could reasonably be inferred or could reasonably be expected that the gift was intended to influence such official, officer or employee in the performance of his or her official duties or was intended to reward official action or inaction. Under no circumstances shall an official, officer or employee accept any gift valued in excess of \$25. No officer or employee of the Town shall grant in the discharge of his duties any improper favor, service or thing of value. Nothing contained herein shall be deemed to prohibit any officer or employee of the Town from borrowing money from any bank or banks designated as depositories by the Town Board.

- F. No Town official, officer or employee shall disclose any confidential information or use said information to further their personal interest or the personal interests of others, unless required to do so by law or court order.
- G. No Town official, officer or employee, whether paid or unpaid, shall engage in or accept private employment or render services for private interests when such employment or service is in conflict with the proper discharge of his official duties.
- H. No Town official, officer or employee shall accept employment by any person, firm or corporation with which he or his department, office or agency is engaged on behalf of the Town in the transaction of business which is or may be affected by his official action. No officer or employee of the Town shall, within one year after termination of service or employment with the Town, appear before any board or agency of the Town in relation to any case, proceeding or application in which he personally participated during the period of his service or employment or which was under his active consideration.
- I. No Town official, officer or employee shall use or attempt to use his official position to secure unwarranted privileges or exemptions for himself or others or grant any special consideration, treatment or advantage to any citizens beyond that which is available to every other citizen.
- J. No Town official, officer or employee shall, by his conduct, give reasonable basis for the impression that any person can unduly influence him or improperly enjoy his favor in the performance of his official duties or that he is affected by the kinship, rank, position or influence of any party or person.
- K. No Town official, officer or employee shall direct or cause any officer or employee of the Town to do or perform any service or work outside of public work or employment, or accept any such service or work, nor shall any officer or employee of the Town offer to or perform any such service or work for such officer or employee.
- L. No Town official, officer or employee shall use or permit the use of Town property (including vehicles, equipment, materials and any other property) for personal convenience, profit, or political means except when such use is available to Town citizens generally or is provided as a matter of written Town policy
- M. No Town official, officer or employee shall require, authorize, or influence any other Town official, officer, or employee to participate in an election campaign or contribute to a political committee.
- N. No Town official, officer or employee shall induce or aid other officials, officers or employees of the Town to violate any provisions of this chapter.
- O. All Town Board members, officials, officers, employees, and volunteers are required to reasonably cooperate with any investigation of the Board of Ethics. Such reasonable cooperation shall include by way of example, but not be limited to, participating in investigatory interviews, producing documents or other tangible information in their possession or control, and appearing at scheduled hearings and giving testimony. Employees represented by a union will have the right to have a union representative present with them for any investigatory interviews and to seek the advice of their union representative prior to appearing before or providing information to the Board of Ethics.
- P. Every Ethics Board Member shall annually complete two hours of ethics training.
- Q. This Ethics Code shall be annually available to all Town officials, Board members, employees, and volunteers.

§ 13-4. Penalties.

- A. In addition to any penalty contained in any other provision of law, a violation of this chapter may result as follows:
 - (1) Forfeiture of pay, suspension or removal from office or employment or such other disciplinary action as the Town Board may consider advisable.
 - (2) Any contract knowingly entered into by and/or with the Town or any agency thereof in which there is an interest or financial benefit prohibited by this chapter shall be null, void, and wholly unenforceable.
 - (3) Recommend a civil fine, not to exceed \$10,000 for each violation, upon a Town Official, Board member, employee or volunteer found guilty of a violation of this code. Such fine shall be payable to the Town.
- B. No action expressly or impliedly permitted under Article 18 of the General Municipal Law shall constitute a violation of this chapter.

§ 13-5. Disclosure statements.

- A. The following Town officials, officers and employees of the Town of West Seneca shall be required to file annual disclosure statements by March 31 of each year in the form set forth in Exhibit "A" attached hereto:¹¹
 - (1) All elected officials.
 - (2) All department heads.

- (3) Any and all Board members, Commission members, Committee members, whether elected, appointed, or volunteer.

[1] *Editor's Note: Said attachment is on file in Town offices.*

- B. Said forms shall be filed with the Town Clerk and shall be available for public inspection.

- C. Any independent contractors hired by the Town to perform any work for the Town shall be required to file annual disclosure statements by March 31 of each year in a form set forth in Exhibit "B" attached hereto.^{12]}

[2] *Editor's Note: Said attachment is on file in Town offices.*

§ 13-6. Whistleblower Policy.

- A. This Whistleblower Policy applies to all board members, officers, employees of the Town of West Seneca, and the public, and provides them with a confidential means to report credible allegation of misconduct, wrongdoing or unethical behavior and to protect those individuals, when acting in good faith, from personal or professional retaliation.

- B. Town employees who discover or have knowledge of potential wrongdoing concerning board members, officers or employees of the Town, or a person having business dealings with the Town, or concerning the Town itself, shall report such activity in accordance with the following procedures:

- (1) The Town employee shall disclose any information concerning wrongdoing either orally or in a written report to his or her supervisor, to the Town Ethics Board Attorney, general counsel, human resources representative, or the Erie County Whistle Blower Hotline at (716-858-7722) or email at whistleblower@erie.gov.

- (2) Town employees who discover or have knowledge of wrongdoing shall report such wrongdoing in a prompt and timely manner. If reporting through the Town Ethics Board Attorney, then the form attached hereto as Exhibit "C"^{1]} shall be completed and submitted to the Town Ethics Board Attorney.

[1] *Editor's Note: Said attachment is on file in Town offices.*

- (3) The identity of the whistleblower and the substance of his or her allegations will be kept confidential to the best extent possible.

- (4) The individual to whom the potential wrongdoing is reported shall investigate and handle the claim in a timely and reasonable manner, which may include referring such information to the authorities or an appropriate law enforcement agency where applicable.

- (5) Should a Town employee believe in good faith that disclosing information within the Town would likely subject him or her to adverse personnel action or be wholly ineffective; the Town employee may instead disclose the information to the local authorities or to an appropriate law enforcement agency, if applicable.

- (6) Should a Town employee believe in good faith that disclosing information within the Town would likely subject him or her to adverse personnel action or be wholly ineffective; the Town employee may instead disclose the information to the local authorities or to an appropriate law enforcement agency, if applicable.

- (7) All allegations of retaliation against a whistleblower or interference with an individual seeking to disclose potential wrongdoing will be thoroughly investigated by the Town Ethics Board.

- (8) Any Town employee who retaliates against or attempts to interfere with any individual for having in good faith disclosed potential violations of the Town's Code of Ethics or other instances of potential wrongdoing is subject to disciplinary action, which may include termination of employment.

- (9) Any allegation of retaliation or interference will be taken and treated seriously and irrespective of the outcome of the initial complaint, will be treated as a separate matter.

- (10) The Whistleblower Policy is not intended to limit, diminish or impair any other rights or remedies that an individual may have under the law with respect to disclosing potential wrongdoing free from retaliation or adverse personnel action.

- (11) Specifically, the Whistleblower Policy is not intended to limit any rights or remedies that an individual may have under the laws of the State of New York, including but not limited to the following provisions: Civil Service Law§ 75-b, Labor Law§ 740, State Finance Law§ 191 (commonly known as the "False Claims Act") and Executive Law§ 55(1).

- (12) With respect to any rights or remedies that an individual may have pursuant to Civil Service Law§ 75-b or Labor Law§ 740, any employee who wishes to preserve such rights shall, prior to disclosing information to a government body, have made a good faith effort to provide the appointing authority or his or her designee the information to be disclosed and shall provide the appointing authority or designee a reasonable time to take appropriate action unless there is imminent and serious danger to public health or safety. [See Civil Service Law§ 75-b(2)(b); Labor Law§ 740(3)].

- C. Once a complaint has been submitted, the Ethics Board will investigate the allegations of the complaint. In conducting any such investigation, the Ethics Board may administer oaths or affirmations, issue subpoenas pursuant to Article 23 of the New York Civil Practice Law and Rules, compel witness attendance and require the production of any books or records which it may deem relevant and material. The Ethics Board shall require clear and convincing evidence before determining that a violation has occurred.

§ 13-7. Creation of Board of Ethics; composition of membership; conditions of membership.

- A. A Board of Ethics is hereby established pursuant to Article 18, Section 808, Subdivision 3 of the General Municipal Law. The members of the Board of Ethics shall be appointed by the Town Board and shall receive no salary or compensation for their services as members of such Board. A member of the Board of Ethics may be removed for cause. The Board shall be composed of one member to be appointed by each member of the Town Board with staggered terms. Three members shall be appointed in 2021 and two members to be appointed in 2022. The term of each member shall be five years with three more being appointed or reappointed in 2026 and two being appointed or reappointed in 2027, which shall continue on the same scheme. A member of the Town Board shall not appoint himself or herself or any other current Town Board member. The seventh member of the Board of Ethics shall be the Town Clerk, who shall be an ex officio member without the power to vote. The members of the Board of Ethics shall be residents of the Town of West Seneca and only one member shall be a current Town official, officer or employee. The Town Attorney representing the Town shall be an ex officio member of the Board of Ethics without the power to vote. In the event that the Town Board increases to five board members, the Board of Ethics shall become a five-member Board. One member shall be appointed by each Town Board member and the terms shall be five years as decided by a majority of the Town Board members.
- B. Advisory opinions. Upon written request of any Town official, officer or employee, the Board of Ethics established herein shall render advisory opinions regarding this chapter of Ethics or the provisions contained in Article 18 of the New York State General Municipal Law. The Board of Ethics shall also make recommendations as to any amendments to this chapter upon the request and majority vote of the Town Board. The opinions of the Board of Ethics shall be advisory and under no circumstances shall the identity of the Town officer, official or employee be disclosed except to authorized persons and agencies or pursuant to a court order.
- C. Rules and regulations. The Board of Ethics shall promulgate its own rules and regulations as to its form and procedures and shall maintain appropriate records of its opinions and proceedings.
- D. All recommendations, advisory opinions and rules and regulations of the Board of Ethics shall be kept in the Town Clerk's Office.

§ 13-8. Severability.

If any portion of this chapter shall be adjudged by a court of competent jurisdiction to be invalid or unconstitutional, such portion thereof shall be deemed inoperative and the balance of the code deemed to be in full force and effect.

§ 13-9. Permissible claims.

Nothing herein shall be deemed to bar or prevent the timely filing by a present or former Town official, officer or employee of any claim, account, demand or suit against the Town or any agency thereof on behalf of himself or any relative or household member arising out of any personal injury or property damage or for any lawful benefit authorized or permitted by law.

§ 13-10. Compliance required; distribution of copies.

Compliance with this Code of Ethics shall be deemed a condition of employment for all Town officials, officers and employees. The Town Human Resources Department must promptly cause a copy of this code, including any amendments, to be distributed to every person who is or becomes an official, officer or employee of the Town of West Seneca and a receipt of the same shall be signed by such official, officer or employee. Such receipts shall be filed with Human Resources, who shall supply the necessary forms, and a photocopy shall be filed in the officer's or employee's personnel folder and with the Board of Ethics.

§ 13-11. When effective.

This chapter shall become effective immediately upon its enactment by the Town Board after proper filing, including filing with the office of the State Comptroller and the office of the Secretary of State.

TOWN OF WEST SENECA



Gary A. Dickson
Supervisor's Office

TOWN SUPERVISOR
Gary A. Dickson
TOWN COUNCIL
William Bauer
Joseph J. Cantafio
Jeffrey Piekarec
William P. Hanley

I hereby acknowledge that I have received a copy of the Town of West Seneca's Code of Ethics (West Seneca Town Code Chapter 13). I have read and understand the aforementioned Code together with all amendments thereto and will abide by them.

Signature: _____

Print Name: _____

Date: _____



FINANCE DEPARTMENT

TOWN OF WEST SENECA

TOWN SUPERVISOR
GARY A. DICKSON

TOWN COUNCIL
WILLIAM BAUER
JOSEPH J. CANTAFIO
WILLIAM P. HANLEY JR.
JEFF PIEKAREC

Congratulations on your appointment with the Town of West Seneca!

As a full-time employee of the Town of West Seneca, you are eligible to receive the following health, dental and vision benefits. If you wish to enroll in any of the following benefits, complete the attached associated applications and remit them to the Finance Department as soon as possible.

Health Insurance Benefits

The Town of West Seneca currently utilizes Highmark of Western New York through the Labor Management Health Fund (LMHF) for its health insurance benefits and Pharmacy Benefits Dimensions for prescription coverage. The following is the pricing for the health benefits you are eligible for. A summary of the associated plans and enrollment application is attached for your convenience.

Plan	BCBS POS201		BCBS TRA901		BCBS POS226D (GOLD)	
	Single	Family	Single	Family	Single	Family
Biweekly Contribution (2022)	\$ 38.46	\$ 76.92	\$ 38.46	\$ 76.92	\$ -	\$ -

Dental/Vision Insurance Benefits

The Town of West Seneca currently utilizes CSEA Employee Benefit Fund for its dental and vision insurance benefits. You are eligible for dental and vision benefits at no cost to you. A summary of the associated plans and enrollment application is attached for your convenience.

For questions regarding health, dental and vision benefits, please contact Alissa Straus, Director of Finance at 716-558-3208 or astraus@twсны.org.



ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN **BLUE** OR **BLACK** INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

- ☐ **ENROLLING**
(Complete sections I, II, IV, and V)
- ☐ **WAIVING**
(Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name		Group Number	Payroll Location
First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)	
Address				
City	State	Zip	County	Home/Cell Phone
Marital Status (Please check one): <input type="checkbox"/> Single/Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Enrollment Status <input type="checkbox"/> Active Employee <input type="checkbox"/> Rehired Employee <input type="checkbox"/> Retiree <input type="checkbox"/> HIPAA Life Event		
Full-Time Hire (or Rehire) Date (Month/Day/Year) ____/____/____		Life Event <input type="checkbox"/> COBRA Continuant Start Date ____/____/____ <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Spouse <input type="checkbox"/> Loss of Student Status <input type="checkbox"/> Dependent reached max age <input type="checkbox"/> Left employ/retirement <input type="checkbox"/> Add Dependent		
Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Date of Birth (Month/Day/Year) ____/____/____	Age	Product Selection(s) <input type="checkbox"/> Medical Product Name: _____ <input type="checkbox"/> Vision <input type="checkbox"/> Dental	
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Are you an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner [†]	
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Date of Birth (Month/Day/Year) ____/____/____	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Full Name of Physician of Record (POR) Group Practice		
POR Number from Provider Directory		Is Spouse/DP an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

[†] If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*	
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) ____/____/____	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**		
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.





DEPENDENT CHILD				
First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*	
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Date of Birth (Month/Day/Year) / /	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental			Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**	
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

DEPENDENT CHILD				
First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*	
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> U	Date of Birth (Month/Day/Year) / /	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental			Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Other	
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL	
I HEREBY DECLINE MEDICAL COVERAGE: <input type="checkbox"/> For myself <input type="checkbox"/> For family members ONLY : <input type="checkbox"/> For myself and ALL family members <input type="checkbox"/> For the following family members: _____	REASON FOR DECLINING MEDICAL COVERAGE: <input type="checkbox"/> Insured under spouse <input type="checkbox"/> Other _____
VISION	DENTAL
I HEREBY DECLINE VISION COVERAGE: <input type="checkbox"/> For myself <input type="checkbox"/> For family members ONLY <input type="checkbox"/> For myself and ALL family members <input type="checkbox"/> For the following family members: _____	I HEREBY DECLINE DENTAL COVERAGE: <input type="checkbox"/> For myself <input type="checkbox"/> For family members ONLY <input type="checkbox"/> For myself and ALL family members <input type="checkbox"/> For the following family members: _____

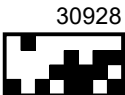
I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage formyself and/ormy dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group’s renewal or until a special enrollment (described below) occurs before coverage will be offered.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed fivethousand dollars and the stated value of the claim for each such violation.

Employee/Contract Holder Signature _____ Date _____

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days after you and your dependent’s other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children’s Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer or call the toll-free Highmark Member Service number: 1-800-241-5704 (TTY/TDD: Dial 711).



IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date / /	Name of Policyholder
Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number	Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Highmark Notice of Privacy Practices is available on the Highmark Web site, or from the Highmark Privacy Office.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms to one of the following addresses:

Fax (833) 619-5746

enrollmentandbillinghighmarkny@highmark.com

Membership Department
P.O. Box 4208
Buffalo, NY 14240-4208

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Coverage Advantage or Highmark Health Insurance Company, all of which are independent licensees of the Blue Cross and Blue Shield Association.

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে অলকাত্ত নম্বর রেতা পররোবায় কল করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لیے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Labor-Management Healthcare Coalition TM

Town of West Seneca

Summary of Benefits

Traditional Blue POS 201/201Plus

Deductibles/Maximums	POS 201	POS 201 Plus
In-network deductible	N/A	
In-network co-insurance	N/A	
Medical in-network out-of-pocket maximum	\$5,125/\$10,250	
Pharmacy in-network out-of-pocket maximum	\$1,725/\$3,450	
Out-of-network deductible	\$250/\$500	
Out-of-network coinsurance	20%	
Out-of-network out-of-pocket maximum	\$2,000/\$4,000	
Annual maximum	Unlimited	
Lifetime maximum	Unlimited	
Benefit administration	Calendar year	
Dependent age	26	
Student age	26	
Dependent/Student coverage ends	End of birth month	
Domestic partner	No Coverage for domestic partner	
Prescription Drug	POS 201	POS 201 Plus
Prescription copay	\$1/\$10/\$25	
Mail order copay per 90-day supply	1 copay	
Option 90 - 90 day supply at retail	2.5 copays	
Physician Services - Office	POS 201	POS 201 Plus
Primary care physician copay	\$5	\$0 or \$5
Specialist copay	\$10	\$15 or \$10
Pediatric visits for children up to age 19	Covered in full	
Well child visits and immunizations for children up to age 19	Covered in full	
Allergy immunotherapy	\$10	\$15 or \$10
Chiropractic	\$5	\$5
Laboratory services	Covered in full	
Radiology (X-ray, MRI, CT and other high-tech imaging)	Covered in full	
Pre and post natal care	Covered in full after initial primary care physician copay	
Physician Services - Preventive	POS 201	POS 201 Plus
Abdominal aortic aneurysm screening	Covered in full	
Adult immunizations (flu vaccinations covered in full)	Covered in full	
Bone mineral density screening	Covered in full	
Routine colorectal cancer screening	Covered in full	
Routine mammogram	Covered in full	
Routine OB/GYN	Covered in full	
Routine pap smear	Covered in full	
Routine physical exam	Covered in full	
PSA test	Covered in full	
Routine eye exam	Covered in full	

Labor-Management Healthcare Coalition TM

Town of West Seneca

Summary of Benefits

Traditional Blue POS 201/201Plus

Hospital	POS 201	POS 201 Plus
Inpatient hospital stay	Covered in full	
Inpatient maternity stay	Covered in full	
Outpatient surgery	\$10	\$15 or \$10
Emergency Hospital Care	POS 201	POS 201 Plus
Emergency room (copay waived if admitted to hospital)	\$35	
Ambulance - ground	Covered in full	
Ambulance - air	Covered in full	
Urgent care centers	\$5	\$0 or \$5
Mental Health and Substance Abuse	POS 201	POS 201 Plus
Inpatient mental health	Covered in full	
Outpatient mental health	Covered in full	
Inpatient alcohol & substance abuse detoxification	Covered in full	
Inpatient alcohol & substance abuse rehabilitation	Covered in full	
Outpatient alcohol & substance abuse	Covered in full	
Other Services	POS 201	POS 201 Plus
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	\$10	\$15 or \$10
Chemotherapy	\$10	\$15 or \$10
Dialysis	\$10	\$15 or \$10
Durable medical equipment	20% copay	
Home care	\$10	\$15 or \$10
Hospice	210 days, Covered in full	
Physical, speech and occupational therapy (30 visits)	\$10	\$15 or \$10
Prosthetic and orthotic appliances	20% copay	
Radiation therapy	\$10	\$15 or \$10
Skilled nursing facility	Unlimited days, Covered in full	
Lasik Eye Surgery (up to \$400 each eye)	50% copay	50% copay
Wellness Benefit	POS 201	POS 201 Plus
Wellness Card	\$250	

revised 1/1/2016 (0001, 0003, 0004, 0002, 0005, 0006)

****This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.**

Labor-Management Healthcare Coalition TM

Town of West Seneca - PBA

Summary of Benefits

Traditional 901 with Major Medical

Deductibles/Maximums	
Major medical deductible	\$50/\$100
Major medical co-insurance	20%
Major medical out-of-pocket maximum (exculding deductible)	\$500/ \$1,000
Pharmacy out-of-pocket maximum	\$6,250/\$12,500
Out-of-network deductible	N/A
Out-of-network co-insurance	N/A
Out-of-network out of pocket maximum	N/A
Annual maximum	Unlimited
Lifetime maximum	Unlimited
Benefit administration	Calendar year
Dependent age	26
Student age	26
Dependent/Student coverage ends	End of birth month
Domestic partner	No Coverage for domestic partner
Prescription Drug	
Prescription copay	Covered under major medical
Medical Services	
Primary care physician copay	Covered under major medical
Specialist copay	Covered under major medical
Pediatric visits for children up to age 19	Covered under major medical
Well child visits and immunizations for children up to age 19	Covered in full
Allergy immunotherapy	Covered under major medical
Chiropractic	Covered under major medical
Laboratory services	Covered in full for the first \$100, then covered under major medical
Radiology (x-ray, MRI, CT & other high tech imaging)	Covered in full
Pre & post natal care	Covered in full
Physician Services - Preventive	
Abdominal aortic aneurysm screening	Covered in full
Adult immunizations (flu vaccinations covered in full)	Covered in full
Bone mineral density screening	Covered in full
Routine colorectal cancer screening	Covered in full
Routine mammogram	Covered in full
Routine OB/GYN	Covered in full
Routine pap smear	Covered in full
Routine physical exam	Covered in full
PSA test	Covered in full
Routine eye exam	Covered in full

Labor-Management Healthcare Coalition TM

Town of West Seneca - PBA

Summary of Benefits

Traditional 901 with Major Medical

Hospital	
Inpatient hospital stay	Covered in full
Inpatient maternity stay	Covered in full
Outpatient surgery	Covered in full
Emergency Hospital Care	
Emergency room (copay waived if admitted to hospital)	Covered in full
Ambulance - ground ambulance	Covered under major medical
Ambulance - air ambulance	Covered under major medical
Urgent care centers	Covered in full
Mental Health & Substance Abuse	
Inpatient mental health	Covered in full
Outpatient mental health	Covered in full
Inpatient alcohol & substance abuse detoxification	Covered in full
Inpatient alcohol & substance abuse rehabilitation	Covered in full
Outpatient alcohol & substance abuse	Covered in full
Other Services	
Cardiac rehabilitation (24 visits within 12 weeks of acute episode)	Covered under major medical
Chemotherapy (Administration)	Covered in full
Dialysis	Covered in full
Durable medical equipment	Covered under major medical
Home care	Covered in full
Hospice	210 days, Covered in full
Physical, speech & occupational therapy	Covered under major medical
Prosthetic and orthotic appliances	Covered under major medical
Radiation therapy	Covered in full
Skilled nursing facility (Not Long Term Care-Rehab only)	Covered under major medical

revised 1/1/2016 (00407270,00407271, 00407272, 0T01/0T09/0T10)

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Labor-Management Healthcare Coalition ®**Town of West Seneca****Summary of Benefits****POS 226D**

Deductibles/Maximums	
In-network deductible	\$500 / \$1,000
In-network co-insurance	N/A
Medical in-network out-of-pocket maximum	\$4,000/\$8,000
Pharmacy in-network out-of-pocket maximum	\$1,350/\$2,700
Out-of-network deductible	\$5,000 / \$10,000
Out-of-network co-insurance	40%
Out-of-network out of pocket maximum	\$10,000 / \$20,000
Annual maximum	Unlimited
Lifetime maximum	Unlimited
Benefit administration	Calendar year
Dependent age	26
Student age	26
Dependent/Student coverage ends	End of birth month
Domestic partner	No Coverage for domestic partner
Prescription Drug	
Prescription copay	\$10 / \$35 / \$70
Mail order copay per 90-day supply	1 copay
Option 90 - 90 day supply at retail	2.5 copays
Medical Services	
Primary care physician copay	\$25 copayment after deductible
Specialist copay	\$40 copayment after deductible
Pediatric visits for children up to age 19	\$25 copayment after deductible
Well child visits and immunizations for children up to age 19	Covered in full
Telemedicine	\$25 copayment after deductible
Allergy immunotherapy	\$25/\$40 copayment after deductible
Chiropractic care	\$40 copay after deductible
Laboratory services	Covered in full after deductible
Radiology (x-ray, MRI, CT & other high tech imaging)	\$25/\$40 copayment after deductible
Pre & post natal care (initial visit)	\$25/\$40 copayment after deductible
Physician Services - Preventive	
Abdominal aortic aneurysm screening	Covered in full
Adult immunizations (flu vaccinations covered in full)	Covered in full
Bone mineral density screening	Covered in full
Routine colorectal cancer screening	Covered in full
Routine mammogram	Covered in full
Routine OB/GYN	Covered in full
Routine pap smear	Covered in full
Routine physical exam	Covered in full
PSA test	Covered in full
Routine eye exam	Covered in full

Labor-Management Healthcare Coalition ®**Town of West Seneca****Summary of Benefits****POS 226D**

Hospital	
Inpatient hospital stay	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Inpatient maternity stay	\$500 per admission, not to exceed \$500 single /\$1,000 family after deductible
Outpatient surgery (in physicians office)	\$25 copay /\$40 copay after deductible
Outpatient surgery (Facility)	\$100 copayment after deductible
Emergency Hospital Care	
Emergency room (copay waived if admitted to hospital)	\$150 copaymnet after deductible
Ambulance - ground ambulance	\$150 copaymnet after deductible
Ambulance - air ambulance	\$150 copaymnet after deductible
Urgent care centers	\$50 copayment after deductible
Mental Health & Substance Abuse	
Inpatient mental health	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Outpatient mental health	\$25 copayment after deductible
Inpatient alcohol & substance abuse detoxification	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Inpatient alcohol & substance abuse rehabilitation	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Outpatient alcohol & substance abuse	\$25 copayment after deductible
Other Services	
Chemotherapy Outpatient Facility	\$40 copayment after deductible
Dialysis	\$40 copayment after deductible
Durable medical equipment	20% coinsurance after deductible
Home health care	\$40 copayment after deductible; 365 visits per plan yr aggregate IN + OON
Hospice	Covered in full after deductible; 210 visits aggregate IN + OON
Pulmonary Rehabilitation	\$40 copayment after deductible; 24 visits per plan yr in a 12 week period , Aggregate IN + OON
Physical, speech & occupational therapy	\$40 copayment after deductible; 30 visits, aggregate IN & OON with PT/ST/OT, per plan year
Prosthetic and orthotic appliances	20% coinsurance after deductible
Skilled nursing facility (Not Long Term Care-Rehab only); Unlimited days	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible

created 12-15-2020 dr

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