TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

NEW HIRE CHECKLIST – FULL-TIME EMPLOYEE

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

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	☐
I-9*	☐
EEO1	☐
PHYSICAL	☐
BACKGROUND CHECK AUTHORIZATION	☐
DRUG TEST AUTHORIZATION	☐
MV AUTHORIZATION AND DRIVER INFO	☐
DIRECT DEPOSIT FORM	☐
ERS APPLICATION	☐
CODE OF ETHICS AND ACKNOWLEDGEMENT	☐
HIGHMARK OF WNY ENROLLMENT FORM (HEALTH)**	☐
CSEAEBF ENROLLMENT FORM (DENTAL & VISION)	☐
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 and sign the Waiver of Benefits on the Highmark of WNY Enrollment Form.

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

For your records:
HEALTHWORKS INSTRUCTIONS – Bring to your drug screen
BENEFIT EXPLANATION – WC & BC
POS201 PLAN INFORMATION

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. Also, failure to meet the contingency requirements may delay your approved start date as well.

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

TOWN OF
WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

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	

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

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_____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**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) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

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

Step 3: Claim Dependent and Other Credits

If your total income will be $200,000 or less ($400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by $2,000 $ _____

Multiply the number of other dependents by $500 . . . . . $ _____

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

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

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 ☐ Married ☐
		Married, but withhold at higher single rate ☐
City, village, or post office	State / ZIP code	**Note:** If married but legally separated, mark an ***X*** in the *Single or Head of household* box.

Are you a resident of New York City? ..... Yes ☐ No ☐

Are you a resident of Yonkers? ..... Yes ☐ No ☐

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

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

Scan here

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

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.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 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)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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
Town of West Seneca	

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
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: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the 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		**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 **For persons under age 18 who are unable to present a document listed above:** **10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION **2.** 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• 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 *(Family Name)* from **Section 1.**	First Name *(Given Name)* 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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	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 *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

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 *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	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) (mm/dd/yyyy)

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 *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	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) (mm/dd/yyyy)

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 *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire *(if applicable)*	New Name *(if applicable)*		
Date *(mm/dd/yyyy)*	Last Name (Family Name)	First Name (Given Name)	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) (mm/dd/yyyy)

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 *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

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_____

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

TOWN OF WEST SENECA PROOF OF PHYSICAL FORM

This form is to be completed by the (prospective) employee's physician and must be presented to Human Resources on the employee's first day of employment. Please be aware that incomplete paperwork may delay employee's start date.

As an alternative to this Physical Form, the Town will accept a record of a physical (documented and signed by a medical provider) that has been performed within the last 12-months, prior to the employee's date of hire.

Employee's Information

Full Name _____
(Last) (First) (Middle Initial)

Address _____
(Number and Street) (Town, State)

Date of Birth _____
(MM/DD/YYYY)

Department _____ Job Title _____

Employee Acknowledgement:

My employment is also contingent upon providing the Town with required proof of a recent medical physical. The Town Board of the Town of West Seneca may refuse to hire candidates whose proof of physical form indicates they are physically unable to perform the work for which they were hired.

_____ _____
Signature of Employee Date

Job Information (Highway, Buildings & Grounds, Sanitation, Sewers, Electrical)

Employees in these departments may be required to perform tasks that involve motions such as:

- Lifting, Pulling or Pushing up to 50 pounds
- Climbing (such as ladders or into equipment)
- Driving
- Bending, Twisting, Stooping
- Operation of motorized equipment
- Standing for at least four (4) hours continuously without a break
- Walking for at least four (4) hours continuously without a break

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

Physician's Statement

Employee Name: _____

Is the employee able to perform the following work duties:

1. Lifting, Pulling or Pushing up to 50 pounds?..... ☐ Yes ☐ No
2. Climbing (such as ladders or into equipment)..... ☐ Yes ☐ No
3. Driving..... ☐ Yes ☐ No
4. Bending, Twisting, Stooping ..... ☐ Yes ☐ No
5. Operation of motorized equipment ..... ☐ Yes ☐ No
6. Standing for at least four (4) hours continuously without a break ..... ☐ Yes ☐ No
7. Walking for at least four (4) hours continuously without a break ..... ☐ Yes ☐ No
8. Is the employee able to perform the essential job functions of the job for which he/she is applying with or without reasonable accommodation? ..... ☐ Yes ☐ No

If the response to any of the above questions was "No", please explain (i.e. lifting restrictions, etc.):

_____

_____

_____

_____

If the response to any of the above questions was "No", please indicate the anticipated duration of the condition:

_____

_____

Provider Name and Name of Practice: _____

Provider Address: _____

Provider Signature: _____

Date: _____

TOWN OF
WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

BACKGROUND CHECK AUTHORIZATION/RELEASE

Print Name: _____
(First) (Middle) (Last)

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: _____ Date of Birth: _____

Telephone: _____ _____ _____
(Home) (Work) (Mobile)

Driver's License Number/State of Issue: _____

The information contained in this application is correct to the best of my knowledge. I hereby authorize the Town of West Seneca and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; current and previous residences; employment history, education background, character references; drug testing, credit report/history, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to the Town of West Seneca or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

I hereby release the Town of West Seneca, the Social Security Administration, and its agents, officials, representative, or assigned agencies, including officers, employees, or related personnel both individually and collectively, from any and all liability for damages of whatever kind, which may, at any time, result to me, my heirs, family, or associates because of compliance with this authorization and request to release.

Signature: _____ Date: _____

TOWN OF
WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

EMPLOYEE AGREEMENT AND CONSENT TO
DRUG AND/OR ALCOHOL TESTING

I hereby agree, upon a request made under the drug/alcohol testing policy of the **Town of West Seneca**, **New York**, to submit to a drug or alcohol test and to furnish a sample of my urine, breath, and/or blood for analysis. I understand and agree that if I at any time refuse to submit to a drug or alcohol test under Town policy, or if I otherwise fail to cooperate with the testing procedures, I may be subject to immediate termination. I further authorize and give full permission to have the Town and/or its Town physician send the specimen or specimens so collected to a laboratory for a screening test for the presence of any prohibited substances under the policy, and for the laboratory or other testing facility to release any and all documentation relating to such test to the Town and/or to any governmental entity involved in a legal proceeding or investigation connected with the test. Finally, I authorize the Town to disclose any documentation relating to such test to any governmental entity involved in a legal proceeding or investigation connected with the test.

I understand that only duly-authorized Town officers, employees, and agents will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary to make employment decisions and to respond to inquiries or notices from government entities.

WE HEREBY RELEASE AND HOLD HARMLESS THE TOWN, ITS OFFICERS, EMPLOYEES, AGENTS, REPRESENTATIVES, CONTRACTORS, GDY, INC. AND ITS EMPLOYEES AND REPRESENTATIVES FROM ANY AND ALL HARM, LIABILITY, CLAIMS, DAMAGES AND COSTS THAT MAY ARISE FROM OR BE RELATED DIRECTLY OR INDIRECTLY TO A DRUG TEST. SUCH HARM, LIABILITY, CLAIMS, DAMAGES AND COSTS SHALL INCLUDE BUT NOT BE LIMITED TO: PHYSICAL HARM OR INJURY; LOSS OF EMPLOYMENT OR ADVERSE JOB ACTION THAT MIGHT ARISE AS A RESULT OF THE TEST; ALLEGED HARM THAT MIGHT RESULT FROM THE RELEASE OR USE OF INFORMATION OR DOCUMENTATION RELATING TO THE TEST.

This policy and authorization have been explained to me in a language I understand, and I have been told that if I have any questions about the test or the policy, they will be answered.

_____ _____
Signature of Employee Date

_____
Employee's Name - Printed

_____ _____
Town Representative Date

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

TOWN OF WEST SENECA PRE-EMPLOYMENT DRUG SCREEN INFORMATION FORM

Town of West Seneca
1250 Union Rd
West Seneca, NY 14224

Employee Name: _____

*****Please bring this form to HealthWorks with you.*****

- Drug screens must be performed at HealthWorks WNY located at 1900 Ridge Rd, West Seneca (Seneca Square Plaza).
- Hours of Operation are Monday – Friday 8:00am – 4:00pm. No appointment is necessary.
- You must bring picture ID. **If you have a CDL License, you will need to present this as ID.**
- Drug screens must be completed within twenty-four (24) hours of receiving the packet.
- Please contact Human Resources at 716.674.7900 with any questions.

HealthWorks

CDL License holders will receive a 10-panel screen. All other new hire candidates will receive a 9-panel screen.

Please process this under the account GDY Professional Investigation.

GDY
PROFESSIONAL
INVESTIGATION

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

TOWN OF WEST SENECA DRIVER INFORMATION AND MOTOR VEHICLE AUTHORIZATION FORM

Driver's Informatio

Full Name _____
(Last) (First) (Middle Initial)

Address _____
(Number and Street) (Town, State)

Date of Birth _____ Department _____ Job Title _____
(MM/DD/YYYY)

Driver's License Number:		Issuing State:
Date License Expires:		License Restrictions:
Do you have a valid CDL? (Y/N):		
How many years have you been driving:		
Passenger Autos:	Trucks/Tractors:	Mobile Equipment:

Have you ever been convicted of an alcohol or drug-related offense- with a motor vehicle? (Y/N) _____
If yes, state when, where, and the outcome: _____
_____

- The Town of West Seneca will need to see your driver's license in order to track important information about your driving qualifications.
- Some positions in the Town are required to participate in a random drug testing program. If you are in one of these roles, your department head will discuss with you.
- In order to drive a Town of West Seneca vehicle, you must receive authorization from your department head.

I am aware that motor vehicle reports may be obtained as part of the Town's evaluation of my employment and/or job application. I, the undersigned, hereby offer my consent and further grant my employer, or prospective employer, and its insurance representatives, permission to request, receive, review, evaluate, and maintain in their files my motor vehicle driver report or abstract of operating records including information that is normal to these reports or abstracts of the state, province, or country to which a request is made.

I acknowledge that I have read this form and I certify that all the answers contained herein are true and complete to the best of my knowledge.

Signature of Employee _____ Date _____

Entered into LENS _____

TOWN OF WEST SENECA
"PROUD PAST - UNLIMITED FUTURE"

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.

Office of the New York State Comptroller
NYSLRS
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

Received Date

Employees' Retirement System Membership Registration
RS 5420
(Rev. 11/22)

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

Registration Number

NYSLRS ID

Social Security Number *

Part 1: Employee – Read information provided on page 2. Complete part 1 and sign at the bottom of the form.

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
		☐ Male ☐ Female ☐ X

Are you receiving or about to receive a pension from a New York State or New York City public retirement system? ☐ Yes ☐ 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? ☐ Yes ☐ 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		
	☐ 12 Month ☐ 10 Month ☐ 12 M Provisional ☐ On Call ☐ Seasonal ☐ Substitute ☐ Per Diem	☐ Regular [2] ☐ Temporary	☐ Full Time ☐ Part Time

Hire Date [3a]			Date of Full-Time Permanent Appointment [3b]			Location Code	Standard Workday [4]	For State Agency Use Only – Agency Code
Month	Day	Year	Month	Day	Year			

For a substitute, seasonal, on call or per diem employee, please check if he/she/they is working on the day the application is being submitted. ☐ **Yes**

Frequency of Payment

☐ Weekly ☐ Bi-Weekly ☐ Semi - Monthly ☐ Monthly ☐ Quarterly ☐ Semi- Annually ☐ Annually ☐ Other- Please Specify_____

Projected Annualized Wage [5]

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.

Important: If your employment is on a part-time, temporary or provisional basis, or less than 12 months a year, membership is optional. If your membership is optional, you must sign and date below to affirm Retirement System Membership.
I acknowledge that my membership in the New York state and Local Retirement System is governed by provisions of Article 15 of the Retirement and Social Security Law and that I am entitled to all the benefits thereof. I understand that, as required by law, a deduction will be made from my salary or compensation for retirement contributions.

Employee's Signature:_____**Date:** _____

Employee's Telephone Number:	Employee's Email Address:

For important information and instructions – See Back Page

Part 1 – Employee Instructions

Important: If your employment is on a part-time, temporary or provisional basis, or less than 12 months a year, membership is optional. If your membership is optional and you **do not wish** to join the Retirement System, do not complete this application.

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 to determine which job code is applicable to the employee's job title. If the title is accountant, auditor, physician, attorney, engineer or architect, please submit documentation as indicated at https://www.osc.state.ny.us/retire/employers/employer_reporting_basics/emp-membership-basics/independent_vs_employee.php

[2] Regular is the same as Permanent or Probationary. Temporary is anything other than regular.

[3a] Hire Date is the first time the employee was hired for the job criteria entered.

[3b] Full-Time permanent appointment box must only be completed if at anytime the employee is appointed to a (permanent or probationary) 12 month, full-time position earning no less than current state minimum wage

[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 still establish a standard workday between six and eight hours as the denominator for their days worked calculation. When entering the information on the Employer Retirement Online, you will need to select "Daily" for Work Period and then enter the standard work day in the standard day 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 Rate / Standard Workday / Days Worked / Annual Wage 10 month Employee: $_____X _____ X 180 = $_____ Hourly Rate / Standard Workday / Days Worked / Annual Wage	**Daily Employees** 12 month Employee: $_____ X 260 = $_____ Daily Rate / Days Worked / Annual Wage 10 month Employee: $_____X 180 = $_____ Daily Rate / Days Worked / Annual 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.[1][1] 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 Law[1][1] 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:[1]
   (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.[2]

[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

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: _____

TOWN OF WEST SENECA

FINANCE DEPARTMENT

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**	
	Single	**Family**
Monthly Premium Cost	$ 880.91	$ 2,477.39
Biweekly Contribution (20%)	$ 81.31	$ 228.68

Dental/Vision Insurance Benefits

The Town of West Seneca currently utilizes CSEA Employee Benefit Fund for it's 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@twsny.org.

30928

HIGHMARK WESTERN NEW YORK

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)*:
❑ Single/Widowed
❑ Married
❑ Divorced

Full-Time Hire (or Rehire) Date *(Month/Day/Year)*

_____/_____/_____

Enrollment Status
❑ Active Employee
❑ Rehired Employee
❑ Retiree
❑ HIPAA Life Event

Life Event
❑ COBRA Continuant Start Date _____/_____/_____
❑ Divorce
❑ Death of Spouse
❑ Loss of Student Status
❑ Dependent reached max age
❑ Left employ/retirement
❑ Add Dependent

Gender	Date of Birth *(Month/Day/Year)*	Age	Product Selection(s)
❑ M ❑ F ❑ U	/ /		❑ Medical Product Name: _____ ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		❑ Yes ❑ 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?
			❑ Spouse ❑ Domestic Partner †

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ M ❑ F ❑ U	/ /	

Product Selection(s):
❑ Medical ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		❑ Yes ❑ 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? ❑ Child
			❑ Step-child ❑ Adopted* ❑ Other*

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s):	Dependent Status if Age 26 or Older
❑ Medical ❑ Vision ❑ Dental	❑ Disabled ❑ Act 4**

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		❑ Yes ❑ 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.

30928

DEPENDENT CHILD

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

DEPENDENT CHILD

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

- ❑ For myself
- ❑ For family members **ONLY**:
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ❑ Insured under spouse
- ❑ Other

_____

VISION

I HEREBY DECLINE VISION COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ 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
/ /			❑ Active ❑ 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	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ 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

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 কার িডে তালিকাভু ক্ত নম্বরর ৃরে তা পররে বায় ৃ ান 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 لئے، 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.

CSEA Employee Benefit Fund Enrollment Form

PO Box 516
Latham, NY 12110
800-323-2732
www.cseaebf.com

Employee Information (Please Print)

Social Security # _____ Date of Birth _____ /_____ /_____

Name (First, Middle Initial, Last) _____ Please (✓) one: ❑ M ❑ F

Street Address _____ Apt. # _____

City _____ State _____ Zip _____

Employee's Daytime Phone # _____ Email _____

Name of Employer _____

Spouse/Domestic Partner Information

Please (✓) one: ❑ Spouse ❑ Domestic Partner* Date of Marriage _____ /_____ /_____ Please (✓) one: ❑ M ❑ F

Name (First, Middle Initial, Last) _____

Date of Birth _____ /_____ /_____ Social Security # _____

Dependent Children Information (For relationship, please indicate: Son, Daughter, Step-child or other)

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

Last Name _____ First Name _____ Date of Birth _____ /_____ /_____ ❑ M ❑ F Relationship _____

If you are enrolling for a CSEA EBF Dental Plan, please answer the following: Do you and/or your dependents have other dental coverage available? ❑ Yes ❑ No

If yes, please indicate: Name of other plan: _____ Effective Date: _____ /_____ /_____

*Important Information concerning dependent coverage

- *Not all employers allow domestic partner coverage.* For New York State Employees; before enrollment of a domestic partner can be completed, the CSEA EBF must receive eligibility confirmation from The NYS Department of Civil Service. For Local Government employees, the confirmation must come from your employer. For purposes of IRS reporting, it is necessary that you provide your domestic partner's social security number on this form.
- When enrolling dependent children, it may be necessary for the CSEA EBF to require and/or request additional information which may include full-time student verification for children ages 19 and over, verification of eligibility by "Proof of Dependency" form, copy of Birth Certificate and/or "Certification of Disability" form.
- In certain instances, a copy of a Marriage Certificate may be requested for proof of eligibility.
- An employee may not be covered both as an employee and as a dependent of an employee. A member who has a spouse eligible for coverage is not eligible to cover a domestic partner. If member and spouse/domestic partner are EBF members, coverage may not be claimed under both plans.

For a detailed outline of eligibility rules, please refer to your Summary Plan Description or visit our website at www.cseaebf.com

I certify that the above information is correct:

Member's Signature _____ Date _____

Labor-Management Healthcare Coalition ™

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	1copay	
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 ™

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.*