TOWN OF SANDWICH

FULL TIME EMPLOYEE BENEFIT HANDBOOK

Treasurer’s Office
130 Main Street
Sandwich, MA 02563

Phone: 508-888-6508
Fax: 508-888-8655
Email: treasurer@sandwichmass.org
WELCOME NEW EMPLOYEE !!!

The following handbook describes the benefits you are entitled to receive as an employee of the Town of Sandwich. These are important forms to be filled out, signed and returned to the Treasurer’s Office in order for you to be paid. Please read the following handbook very carefully, fill out the applicable paperwork and call 508-888-6508 to make an appointment to return your forms to the Treasurer’s Office.

CHANGE OF STATUS NOTIFICATION – IT IS YOUR RESPONSIBILITY!!!

It is extremely important that the Treasurer’s Office be notified of any changes in the employee’s family status. This includes: Marriage, divorce, death, dependent child reaching of age, etc. This ensures proper insurance coverage and accurate premium payments.

IN ADDITION

It is YOUR responsibility to properly complete and return in a timely manner ALL of the attached forms!!! We appreciate your cooperation and understanding in this manner.

Sincerely,

William Jennings
Town Treasurer
TOWN OF SANDWICH EMPLOYEE BENEFITS

RETIREMENT

All employees full or part-time must contribute to one of the retirement plans in lieu of paying Social Security. All employee deductions for retirement are federally tax sheltered. In addition, employees may claim up to $2000 in retirement deductions each year on their state income taxes.

County Retirement

All permanent full-time employees of the Town of Sandwich who are not members of the Massachusetts Teacher’s Retirement System must join the Barnstable County Retirement System. For purposes of retirement, “full-time” refers to any employee who works 25 or more hours per week. If an employee is already an active member of any retirement system in the Commonwealth, his deduction rate will continue at the same rate, that is, at 5, 7, 8, and 9% of the gross pay. New employees not previously in a retirement system within the Commonwealth will have 9% of their regular (no overtime) pay deducted for retirement.

Employees must complete a retirement enrollment form. If they are new members of the Barnstable County Retirement System, they must also provide a copy of their birth certificate. In addition, if the employee is a veteran, they must provide a copy of his discharge papers. Copies of all these documents are forwarded to the Barnstable County Retirement System where they are kept on file.

In addition, the Barnstable County Retirement System has adopted the 30 Plus ruling, which affects those employees who earn more than $30,000 annually and who enrolled in the retirement system on or after January 1, 1979. It is the employee’s responsibility to request a refund from the retirement board after the Town submits the separation paperwork.

Teacher’s Retirement

Employees who are full-time salaried teachers (and in some cases part-time teachers) must join the Massachusetts Teacher’s Retirement System. The Teacher’s Retirement enrollment process is performed online and a copy returned to the Treasurer’s office. A new contribution rate of 11% applies to those who join on or after July 1, 2001, those existing members who transfer to this district on or before July 1, 2001 and those who have previously elected to participate in Retirement Plus.

The Massachusetts Teacher’s Retirement Board has adopted the 30 Plus ruling. This affects those employees whose deduction rates are not 11%, those who earn more than $30,000 annually and those who enrolled in the retirement system on or after January 1, 1979.

The correct deduction rate (5, 7, 8, 9, 11%) is withheld from your pay by the Treasurer’s office. Teachers leaving employment need to contact the Teacher’s Retirement Board.
Mandatory – 457 Tax Deferred Compensation

All permanent part-time employees who are not enrolled in a County or State retirement system, must participate in the Town mandated “457-Social Security Compliance” (Federal and State tax deferred), retirement plan. Employees will have 7.5% of their pay deducted for retirement. This is in lieu of paying into Social Security. This money will stay in an interest bearing account until such time as the employee permanently leaves the employment of the Town and withdraws it by contacting the Treasurer’s office. It is an option of the employee to leave the money in the account until he/she is age 70 ½ yrs. old. The account representative for Mass Mutual is Sylvia Connor. She may be reached at the following number 1-508-888-5543.

Elected Officials may join the Barnstable County Retirement or The Mass Mutual 457 Plan.

TAXES

Federal Taxes

When hired, each employee should fill out a “W-4 Federal Tax Withholding” form. The employee must state marital status and the number of exemptions he/she will be claiming. Single employees must so designate themselves. However, married employees may check off the box marked “married but withhold at higher single rate”, if they desire increased Federal withholdings. The employee may also list additional dollar amounts to be withheld if he/she so desires, but the additional amount will present a payroll problem if a paycheck were to be issued for that same amount or less.

The employee should make sure that he/she has included his/her name, mailing address and Social Security Number on the form and that it is signed and dated. Employees may change their Federal Withholding status at any time by filling out a new W-4 form.

State Taxes

If an employee wishes to have the State withholdings exemption status different from the Federal withholding status, an M-4 State Withholding form must also be completed. Otherwise, the W-4 will be used for both Federal and State Withholdings.

Medicare

All employees hired by the Town of Sandwich on or after April 1, 1986 are subject to the Federal Medicare tax, which is 1.45% of gross pay.

EMPLOYMENT ELIGIBILITY VERIFICATION FORM (I-9)

Each employee is required to fill out an I-9 form. This verifies that you are eligible to work in the United States. Please fill out Section 1 of the I-9 and bring two forms of identification to our office, we will make copies for our records. See reverse side of the I-9 form for the acceptable forms of ID requested. Return this form to the Treasurer’s office. Please do not forget to date and sign this form.
INSURANCE

Medical/Dental Insurance:
The following plans are offered through MIIA, Massachusetts Interlocal Insurance Association. They are: Blue Cross Blue Shield Network Blue PPO and Blue Care Elect HMO. The one dental plan offered is Blue Cross Blue Shield Dental Blue Freedom. Please call the Treasurer’s office to make an appointment to have any questions answered and to fill out the proper paperwork. (508) 888-6508.

ELIGIBILITY: All permanent employees working 20 or more hours per week, 52 weeks a year are eligible. As of May 3, 2004, anyone signed up for health insurance must provide a marriage certificate and birth certificate/legal documentation for all enrollees.

All new employees have 30 days from their hire date to enroll in a medical and/or dental plan. If you plan to join BC/BS, and the enrollment form was not signed and returned to the Treasurer’s office in this time period, or if you waive or terminate coverage and wish to be covered at a later date, you will have to wait for the next open enrollment period – usually mid April through mid May of each year. Coverage takes effect on July 1 for anyone enrolling during open enrollment. Those who meet certain qualifications may apply for coverage other than at open enrollment. Employees may change from one plan to another only during the April-May open enrollment period.

As of September 1, 1997 employees have the option of choosing their dental plan, with or without choosing a medical insurance. If you plan to join Dental Blue Freedom, and the enrollment form was not returned to the Treasurer’s office within 30 days from date of hire, or if you waive/terminate coverage and wish to be covered at a later date, you will have to wait to enroll during the next open enrollment period – usually mid April through mid May of each year.

Employees pay only 25% of the insurance premium (Town of Sandwich contributes 75%), which is deducted from your paycheck on a Bi-Weekly basis. Under specific guidelines an employee may have reason to pay monthly through a cash payment plan with the Treasurer’s office. The premium deductions are included in the package.

It is the employee’s responsibility to notify the Treasurer’s office in writing of any changes in family status (i.e., marriage, divorce, death, dependent child reaches age 26 for dental and health insurance, birth of child, etc.) to ensure no interruptions in coverage and to guarantee COBRA rights. In this handbook is an “Employee Health Insurance Responsibility Disclosure Form” (HIRD). Please sign this form and return it to the Treasurer’s office.
SPECIAL ENROLLMENT RULES

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your spouse and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

LIFE INSURANCE:

ELIGIBILITY: All permanent employees working 1040 or more hours per year.

Boston Mutual:  

**Basic Life** — Eligible Town of Sandwich employees may opt to purchase a $2000 term life insurance policy with Boston Mutual through the Town of Sandwich. The life insurance may be purchased without enrolling in the Health plan, **but if enrolled in the Health plan the Basic life insurance becomes mandatory.** The premiums are deducted Bi-Weekly from the paycheck as follows:

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<tr>
<th>Pays</th>
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<td>26</td>
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(school personnel only)

Voluntary Life:  

In addition to purchasing the $2000 basic life insurance, employees may also purchase additional life insurance with Boston Mutual through the Town of Sandwich. An eligible employee may purchase term life insurance up to 5 times the amount of his/her annual salary, (minus the $2000 Basic Life). All premiums for this insurance are 100% payable by the employee and deducted from the employee’s paychecks on a Bi-Weekly basis. The cost of the insurance per month is attached with the Voluntary Life information.

Please fill out the attached Boston Mutual Life Insurance form and return it to the Treasurer’s office.
CAFETERIA PLAN

The Town of Sandwich has adopted Section 125 of the Internal Revenue Code, which allows insurance premiums to be deducted from employees’ paychecks in pre-tax dollars. This reduces the individual tax liability per paycheck. When an employee is enrolled in this plan, he/she cannot use the insurance premiums withheld from any pay as year end tax deductions when filing Federal/State tax returns. The administrator of this plan is “Cafeteria Plan Advisors, Inc.”, to which an administrative fee must be paid. This fee will be deducted from your paycheck on a Bi-Weekly basis in the following amounts:

- 26 pays $ .50
- 21 pays $ .60 (school personnel only)

Employees having medical/dental insurance will automatically be enrolled in the plan. If you need further details on this plan feel free to contact CPA, Inc. at 781-848-9848.

PLEASE NOTE: The optional life insurance is not included on the Section 125 Cafeteria Plan. Premium deductions are therefore subject to full taxation.

TAX SHELTERED ANNUITIES

403 (b) Plans

Full-time employees of the Sandwich School Department are eligible to enroll in a 403 (b) tax-sheltered plan. Employees, who wish to participate, may obtain a list of authorized annuity companies at the Treasurer’s office. The Town of Sandwich does not sponsor any one 403 (b) Plan, but simply allows its employees to participate in a plan of their choosing, provided this plan has been approved by the school business manager in accordance with the state and federal laws. The requirements for participating in a 403 (b) Plan through the Town of Sandwich as follows:

1. Employees may sign up for new agreements and make changes in existing agreements on a quarterly basis.
2. Employees may cancel an annuity at any time.
3. The employee must submit to the Treasurer’s office a “Salary Reduction Agreement” which he/she has signed. This agreement must contain the name of annuity company and the amount to be deducted per pay. Annuity deductions are submitted to the Annuity companies on a bi-weekly basis.
Voluntary – 457 Tax-Deferred Compensation

The Town of Sandwich sponsors one voluntary 457 Tax-Deferred Compensation Program. This program is administrated by Mass Mutual Insurance Group. If an employee is already enrolled in a 403 (b) Plan his/her 457 dollar limitation will be reduced by the amount of his/her 403 (b) contribution. If an employee wishes to participate in the program, enrollment forms, as well as specific information about the 457 Tax-Deferred Compensation Plan, may be obtained by contacting The Treasurer’s Office, Mass Mutual at 1-800-637-6444, or their registered representative Sylvia Connor at 508-888-5543. Copies of the enrollment form must be submitted to the Treasurer’s office. These forms must contain the name of the company and the amount that the employee wishes to have deducted per pay.

Enrollments may be done at any time. Employees may make changes in existing agreements on a quarterly basis.

DIRECT DEPOSIT

The Town of Sandwich pays their employees by Direct Deposit. Please complete the attached Direct Deposit form and attach a voided check or a written letter from the bank for account verification.

CHANGE OF STATUS – VERY IMPORTANT

It is extremely important that the Treasurer’s Office is notified any time there is a change in the employee’s family status. This includes: Marriage, divorce, death, dependent child reaching age 19 for Dental Insurance (23 if a student) and age 26 for Health etc. ANY CHANGE IN FAMILY STATUS requires the employee to notify the Treasurer’s Office. This is to ensure proper insurance coverage and accurate premium payments. Thank you.
Town of Sandwich
Guidance Document on the
PREGNANT WORKERS FAIRNESS ACT
Issued March 12, 2018

The Pregnant Workers Fairness Act ("the Act") amends the current statute prohibiting discrimination in employment, G.L. c. 151B, §4, enforced by the Massachusetts Commission Against Discrimination (MCAD). The Act, effective on April 1, 2018, expressly prohibits employment discrimination on the basis of pregnancy and pregnancy-related conditions, such as lactation or the need to express breast milk for a nursing child. It also describes employers' obligations to employees that are pregnant or lactating and the protections these employees are entitled to receive. Generally, employers may not treat employees or job applicants less favorably than other employees based on pregnancy or pregnancy-related conditions and have an obligation to accommodate pregnant workers.

Under the Act:

- Upon request for an accommodation, the employer has an obligation to communicate with the employee in order to determine a reasonable accommodation for the pregnancy or pregnancy-related condition. This is called an "interactive process," and it must be done in good faith. A reasonable accommodation is a modification or adjustment that allows the employee or job applicant to perform the essential functions of the job while pregnant or experiencing a pregnancy-related condition, without undue hardship to the employer.

- An employer must accommodate conditions related to pregnancy, including post-pregnancy conditions such as the need to express breast milk for a nursing child, unless doing so would pose an undue hardship on the employer. "Undue hardship" means that providing the accommodation would cause the employer significant difficulty or expense.

- An employer cannot require a pregnant employee to accept a particular accommodation, or to begin disability or parental leave if another reasonable accommodation would enable the employee to perform the essential functions of the job without undue hardship to the employer.

- An employer cannot refuse to hire a pregnant job applicant or applicant with a pregnancy-related condition, because of the pregnancy or the pregnancy-related condition, if an applicant is capable of performing the essential functions of the position with a reasonable accommodation.
• An employer cannot deny an employment opportunity or take adverse action against an employee because of the employee's request for or use of a reasonable accommodation for a pregnancy or pregnancy-related condition.

• An employer cannot require medical documentation about the need for an accommodation if the accommodation requested is for: (i) more frequent restroom, food or water breaks; (ii) seating; (iii) limits on lifting no more than 20 pounds; and (iv) private, non-bathroom space for expressing breast milk. An employer, may, however, request medical documentation for other accommodations.

• Employers must provide written notice to employees of the right to be free from discrimination due to pregnancy or a condition related to pregnancy, including the right to reasonable accommodations for conditions related to pregnancy, in a handbook, pamphlet, or other means of notice no later than April 1, 2018.

• Employers must also provide written notice of employees' rights under the Act: (1) to new employees at or prior to the start of employment; and (2) to an employee who notifies the employer of a pregnancy or a pregnancy-related condition, no more than 10 days after such notification.

The foregoing is a synopsis of the requirements under the Act, and both employees and employers are encouraged to read the full text of the law available on the General Court's website here: https://malegislature.gov/Laws/SessionLaws/Acts/2017/Chapter54.

If you believe you have been discriminated against on the basis of pregnancy or a pregnancy-related condition, you may file a formal complaint with the Town of Sandwich Human Resources Department. They are located at Sandwich Town Hall, 130 Main Street, Sandwich, MA 02563 and can be reached by calling 508-833-8061.

Also, if you believe you have been discriminated against on the basis of pregnancy or a pregnancy-related condition, you may file a formal complaint with MCAD. You may also have the right to file a complaint with the Equal Employment Opportunity Commission if the conduct violates the Pregnancy Discrimination Act, which amended Title VII of the Civil Rights Act of 1964. Both agencies require the formal complaint to be filed within 300 days of the discriminatory act. Please be advised that you are not required to file a formal complaint with the Town of Sandwich as a condition with filing a complaint with the MCAD and/or EEOC.

If you have any questions, please contact the Human Resources Department at 508-833-8061.
Town of Sandwich

Emergency Contact Information

(Optional)

Employee Name

Emergency contact person

Relationship to employee

Emergency contact phone number

Signature

Date
Employee’s Withholding Certificate

Step 1: Enter Personal Information

- First name and middle initial
- Last name
- Social security number
- Address
- City or town, state, and ZIP code
- Single or Married filing separately
- Married filing jointly (or Qualifying widow(er))
- Head of household (Check only if you’re unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual)

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

Step 2: Multiple Jobs or Spouse Works

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

Do only one of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); or
(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; or
(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld.

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

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

Step 3: Claim Dependents

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

Multiply the number of qualifying children under age 17 by $2,000
Multiply the number of other dependents by $500
Add the amounts above and enter the total here

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

Step 5: Sign Here

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

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

Date

Employers Only

Employer’s name and address

First date of employment

Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 3.
General Instructions

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.

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 and you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less) than the sum of lines 18a, 18b, and 18c; 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 2020 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 1a, 1b, and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator, 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). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:
1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

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 these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead 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. Step 3 of Form W-4 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. 972, Child Tax Credit and Credit for Other Dependents. You can also include other tax credits in this step, such as education tax credits and the foreign tax credit. 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 2020 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.
Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than $120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3.

   1 $

2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.

   a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a.

   2a $

   b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b.

   2b $

   c Add the amounts from lines 2a and 2b and enter the result on line 2c.

   2c $

3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc.

   3

4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld).

   4 $

Step 4(b)—Deductions Worksheet (Keep for your records.)

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income.

   1 $

2 Enter:
   - $24,800 if you're married filing jointly or qualifying widow(er)
   - $16,650 if you're head of household
   - $12,400 if you're single or married filing separately

   2 $

3 If line 1 is greater than line 2, subtract line 2 from line 1. If line 2 is greater than line 1, enter "-0-".

   3 $

4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Schedule 1 (Form 1040 or 1040-SR)). See Pub. 505 for more information.

   4 $

5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4.

   5 $
## Married Filing Jointly or Qualifying Widow(er)

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
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## Single or Married Filing Separately

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<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
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<td>$70,000 - 79,999</td>
<td>$800</td>
</tr>
<tr>
<td>$80,000 - 89,999</td>
<td>$900</td>
</tr>
<tr>
<td>$90,000 - 99,999</td>
<td>$1,000</td>
</tr>
<tr>
<td>$100,000 - 109,999</td>
<td>$1,100</td>
</tr>
</tbody>
</table>

## Head of Household

<table>
<thead>
<tr>
<th>Higher Paying Job Annual Taxable Wage &amp; Salary</th>
<th>Lower Paying Job Annual Taxable Wage &amp; Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - 9,999</td>
<td>$0</td>
</tr>
<tr>
<td>$10,000 - 19,999</td>
<td>$200</td>
</tr>
<tr>
<td>$20,000 - 29,999</td>
<td>$300</td>
</tr>
<tr>
<td>$30,000 - 39,999</td>
<td>$400</td>
</tr>
<tr>
<td>$40,000 - 49,999</td>
<td>$500</td>
</tr>
<tr>
<td>$50,000 - 59,999</td>
<td>$600</td>
</tr>
<tr>
<td>$60,000 - 69,999</td>
<td>$700</td>
</tr>
<tr>
<td>$70,000 - 79,999</td>
<td>$800</td>
</tr>
<tr>
<td>$80,000 - 89,999</td>
<td>$900</td>
</tr>
<tr>
<td>$90,000 - 99,999</td>
<td>$1,000</td>
</tr>
<tr>
<td>$100,000 - 109,999</td>
<td>$1,100</td>
</tr>
<tr>
<td>$110,000 - 120,000</td>
<td>$1,200</td>
</tr>
</tbody>
</table>

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*Form W-4 (2020)*

Page 4
MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Employee:
File this form or Form W-4 with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:
Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2." 

2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "6." See Instruction C.

3. Write the number of your qualified dependents. See Instruction D.

4. Add the number of exemptions which you have claimed above and write the total.

5. Additional withholding per pay period under agreement with employer $ __________________________

   A. □ Check if you will file as head of household on your tax return.
   B. □ Check if you are blind.
   C. □ Check if spouse is blind and not subject to withholding.
   D. □ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date __________________________ Signed __________________________

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. If you claim more than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write "4" in line 2. Using "4" is the withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependent(s) total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

IF THE ALLOWABLE MASSACHUSETTS WITHHOLDING EXEMPTIONS ARE THE SAME AS YOU ARE CLAIMING FOR U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.
Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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

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

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
<th>Middle Initial</th>
<th>Other Last Names Used (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>Apt. Number</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>U.S. Social Security Number</th>
<th>Employee's E-mail Address</th>
<th>Employee's Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

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

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

- [ ] 1. A citizen of the United States
- [ ] 2. A noncitizen national of the United States (See instructions)
- [ ] 3. A lawful permanent resident (Alien Registration Number/USCIS Number):
- [ ] 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy):

  Some aliens may write "N/A" in the expiration date field. (See instructions)

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

1. Alien Registration Number/USCIS Number: __________________________________________

2. Form I-94 Admission Number: __________________________________________

3. Foreign Passport Number: __________________________________________

  Country of Issuance: __________________________________________

Signature of Employee: ____________________________

Today's Date (mm/dd/yyyy): ____________________________

Preparer and/or Translator Certification (check one):

- [ ] I did not use a preparer or translator.
- [ ] A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator: ____________________________

Today's Date (mm/dd/yyyy): ____________________________

<table>
<thead>
<tr>
<th>Last Name (Family Name)</th>
<th>First Name (Given Name)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address (Street Number and Name)</th>
<th>City or Town</th>
<th>State</th>
<th>ZIP Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

STOP Employer Completes Next Page STOP

Form I-9 10/21/2019 Page 1 of 3
Section 2. Employer or Authorized Representative Review and Verification

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

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

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

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

Signature of Employer or Authorized Representative: ___________________________

Today’s Date (mm/dd/yyyy): ___________________________

Title of Employer or Authorized Representative: ___________________________

Last Name of Employer or Authorized Representative: _________________________

First Name of Employer or Authorized Representative: ________________________

Employer’s Business or Organization Address (Street Number and Name): ____________

City or Town: ___________________________

State: ___________________________

ZIP Code: ___________________________

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

A. New Name (if applicable) ___________________________

B. Date of Rehire (if applicable) (mm/dd/yyyy) ___________________________

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

Document Title: ___________________________

Document Number: ___________________________

Expiration Date (if any) (mm/dd/yyyy): ___________________________

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative: ___________________________

Today’s Date (mm/dd/yyyy): ___________________________

Name of Employer or Authorized Representative: ___________________________
LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

<table>
<thead>
<tr>
<th>LIST A</th>
<th>Documents that Establish Both Identity and Employment Authorization</th>
<th>OR</th>
<th>LIST B</th>
<th>Documents that Establish Identity</th>
<th>AND</th>
<th>LIST C</th>
<th>Documents that Establish Employment Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. U.S. Passport or U.S. Passport Card</td>
<td>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</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</td>
<td>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</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</td>
<td>3. School ID card with a photograph</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Employment Authorization Document that contains a photograph (Form I-766)</td>
<td>4. Voter’s registration card</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status:</td>
<td>5. U.S. Military card or draft record</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>a. Foreign passport; and</td>
<td>6. Military dependent’s ID card</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>b. Form I-94 or Form I-94A that has the following:</td>
<td>7. U.S. Coast Guard Merchant Mariner Card</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) The same name as the passport; and</td>
<td>8. Native American tribal document</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>(2) An endorsement of the alien’s nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.</td>
<td>9. Driver’s license issued by a Canadian government authority</td>
<td></td>
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</tr>
<tr>
<td>6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RFMI) 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 RFMI</td>
<td>For persons under age 18 who are unable to present a document listed above:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>10. School record or report card</td>
<td></td>
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<tr>
<td></td>
<td>11. Clinic, doctor, or hospital record</td>
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<tr>
<td></td>
<td>12. Day-care or nursery school record</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>1. A Social Security Account Number card, unless the card includes one of the following restrictions:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>(1) NOT VALID FOR EMPLOYMENT</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>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</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>4. Native American tribal document</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>5. U.S. Citizen ID Card (Form I-197)</td>
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</tr>
<tr>
<td></td>
<td>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</td>
<td></td>
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<tr>
<td></td>
<td>7. Employment authorization document issued by the Department of Homeland Security</td>
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</tr>
</tbody>
</table>

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

Refer to the instructions for more information about acceptable receipts.
Direct Deposit Information
(Please attach “VOID” check)

I request my employer, Town of Sandwich, to automatically deposit my pay to my checking and/or savings accounts at

Bank Name(s):

And to make adjustment entries, if necessary, only under the conditions on the bottom of this form.

Employee Name (Please Print)

You MUST attach a voided check or letter for savings and return to the payroll department. (Check checking or savings)

Routing # Account # $ amount (C) (S)
Routing # Account # $ amount (C) (S)
Routing # Account # $ amount (C) (S)

Amounts must be in $ or All, or Remaining pay. May not be in %. If this is a SAVINGS account we require a letter/documentation that you have an active savings account, routing & account number must be provided. You have to be on the account in order to have these funds deposited.

Direct Deposit Authorization Agreement

I authorize and request my employer to automatically deposit any amounts owing to me to my account at my Depository Financial Institution(s) listed above. I understand that this agreement may be terminated by me or my employer at any time by written notification.

I authorize my employer to debit my account only for the purpose of correcting an erroneous credit previous initiated to my account provided that prior to the debit, my employer has notified me in writing of such debit and therefore.

Email Address

Email me a PDF of my Direct Deposit: Yes______ NO _____

I have read and understood all the terms of this form.

____________________ / _____ /______
Employee Signature Date
Information about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004] requires State and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future Social Security benefits to which they may become entitled.

Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security, is the document that employers should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:
- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, [www.socialsecurity.gov/online/ssa-1945.pdf](http://www.socialsecurity.gov/online/ssa-1945.pdf). Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.
Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name ___________________________ Employee ID# ___________________________

Employer Name ___________________________ Employer ID# ___________________________

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $365.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of $600 based on earnings that are not covered under Social Security, two-thirds of that amount, $400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a $500 widow(er) benefit, you will receive $100 per month from Social Security ($500 - $400=$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee ___________________________ Date ___________________________

Form SSA-1945 (01-2013)
Destroy Prior Editions
New Member Enrollment Form

Barnstable County Retirement Association
750 Attucks Lane
Hyannis, MA 02601

Employee Name

<table>
<thead>
<tr>
<th>Last:</th>
<th>First:</th>
<th>Middle:</th>
<th>Social Security Number</th>
</tr>
</thead>
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Date of Birth: ______/_____/______

Sex: M____ F____

Birth Name or Former Name: (If different)

Are you a Veteran? Y____ N____

If Yes, Dates of Active Military Service:

Provide a copy of your military discharge - Form DD 214

Mailing Address

Street: ______________________ City/Town: __________ State/Zip Code: ________

Residential Address (If different)

Street: ______________________ City/Town: __________ State/Zip Code: ________

Phone: ______________________

Marital Status: M____ S____ W____ D____

# of Children: ______________________

Spouse's Name: ______________________

Spouse's Date of Birth: ______________________

Employment

Agency/Department: ______________________

Start Date: ______________________

Job Title/Position: ______________________

Rate of Regular Compensation: ______________________

Past Retirement Membership Information

Are you retired from any Massachusetts public retirement system? Y____ N____

Were you ever a member of any other Massachusetts public retirement system? Y____ N____

If yes, please list the system, membership dates, status of funds. (attach list if more space needed)

Name of Retirement System: ______________________

Dates: From _______ To _______ Funds still on Deposit: Y____ N____

Name of Retirement System: ______________________

Dates: From _______ To _______ Funds still on Deposit: Y____ N____

If you were a part-time employee for a municipality at any time, you may be eligible to purchase past creditable service. Please contact the retirement office for further information.
Employee Full Name: __________________________ Social Security Number: __________________________

I hereby authorize the Treasurer to withhold the proper percent of my regular compensation due on each pay period and to deposit such deductions to my credit in my annuity savings funds. I understand the full amount of such deductions, with regular interest as provided by law, will be returned upon my written request if I terminate my service, unless I plan to accept a position which would entitle me to become a member of any other contributory retirement system in the Commonwealth. In the event that I die before retiring, my beneficiary or beneficiaries may receive survivor benefits or a refund of my accumulated total deductions as allowed by law.

I sign this form under the pains of perjury. I affirm that the information presented in this form is correct, complete and accurately presented. I understand that giving false or incomplete information may subject me to the loss of my benefits as well as civil and criminal penalties.

The Barnstable County Retirement Board requires a copy of your birth record, proof of name change (if applicable), and military discharge papers, DD-214 (if applicable), be submitted with this form.

Member's Signature __________________________ Date ______________

**MUST BE COMPLETED BY PAYROLL/PERSONNEL DEPARTMENT**

<table>
<thead>
<tr>
<th>Name of Employee:</th>
<th>Job Title or Position:</th>
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<table>
<thead>
<tr>
<th>Date of Hire:</th>
<th>Start Date with BCRA:</th>
<th>Date of First Deduction:</th>
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<td>___ / ___ / ___</td>
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<tr>
<th>Salary Information:</th>
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<tbody>
<tr>
<td>Annual: $__________</td>
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<td>Weekly/biweekly: $___</td>
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<td>Hourly: $___</td>
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<tr>
<th>Employment Status (check all that applies):</th>
<th>Rate of Retirement Deduction:</th>
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<tbody>
<tr>
<td>Permanent</td>
<td>○ 9%</td>
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<tr>
<td>Temporary</td>
<td>○ 8%</td>
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<tr>
<td>Full-Time</td>
<td>○ 7%</td>
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<tr>
<td>Part-Time, % worked</td>
<td>○ 5%</td>
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Is this an Elected Position? Y____ N____  
If Yes, Date First Elected: ___ / ___ / ___

Authorized Signature: __________________________ Date __________

Print Name: __________________________

- [ ] Beneficiary Form is completed with signature and witness signature
- [ ] Birth Certificate is attached
- [ ] SSA-1945 is attached
- [ ] Military DD-214 is attached (if applicable)

Revised 2019
Employee Name:

(Last) (First) (Middle)

Nomination of Beneficiary

Beneficiary Information
Beneficiary or beneficiaries nominated will receive the proportion designated upon your death. As a member, you have the right to change the nominated beneficiary(ies) at any time.

A BENEFICIARY FORM WITH CORRECTIONS OR ERASURES WILL NOT BE ACCEPTED

THE FOLLOWING MUST BE COMPLETED TO ESTABLISH MEMBERSHIP

<table>
<thead>
<tr>
<th>Name and Address Of Beneficiary</th>
<th>Beneficiary Date of Birth</th>
<th>Relationship to Member</th>
<th>Designation Primary/Contingent</th>
<th>Proportion of Benefit</th>
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Please mail signed ORIGINAL to the Barnstable County Retirement Association

Signature: ___________________________ Date: ____________

Signature of Witness: ___________________________ Witness CANNOT be Beneficiary

You are Required to Name a Primary—Must Total 100%. If for some reason the Primary Beneficiary(ies) is/are unable to collect their portion of the benefit then the Contingent (secondary) Beneficiary(ies) will. If naming a Contingent, please Specify. A Change of Beneficiary Form must be used if you wish to change your designated beneficiary(ies). You may obtain this form and others at www.barnstablecounty.org under Affiliated Organizations, select Retirement Association. Or contact the Barnstable County Retirement Office 508-775-1110.

Revised 2019
Official Acknowledgment for Exempt Employees

I, ____________________________, do hereby officially acknowledge that I have been supplied with a copy of the Conflict of Interest Law summary as provided under Chapter 2268A of the Massachusetts General Laws.

______________________________
Signature

______________________________
Position with the Town of Sandwich

______________________________
Department

______________________________
Date
Memo

To: All Employees

From: William Jennings – Town Treasurer

Date: January 8, 2016

Re: New Requirements under Ethics Reform

Ethics Reform Act every municipal employee shall have or do the following:

Conflict of Interest Summary

Each employee must also be provided with a copy of the document entitled “Summary of the Conflict of Interest Law for Municipal Employees.” A copy of this twelve page summary is attached.

Official Acknowledgement

The one page acknowledgement is attached. The employee needs to print his/her name, sign his/her name, list his/her position and in the department he/she works and date. The employee must sign and date the Official Acknowledgement form.

On-Line Training - Full Time and Part Time Year Round Employees

The On-line training program is located at:

HTTP://www.muniprog.eth.state.ma.us/

Upon completion of the training session the program will issue the employee a receipt, of which 2 copies need to be printed. One copy will be submitted to the Clerk’s Office and the other retained for the employee’s personal records.
Summary of the Conflict of Interest Law for Municipal Employees

This summary of the conflict of interest law, General Laws chapter 268A, is intended to help municipal employees understand how that law applies to them. This summary is not a substitute for legal advice, nor does it mention every aspect of the law that may apply in a particular situation. Municipal employees can obtain free confidential advice about the conflict of interest law from the Commission’s Legal Division at our website, phone number, and address above. Municipal counsel may also provide advice.

The conflict of interest law seeks to prevent conflicts between private interests and public duties, foster integrity in public service, and promote the public’s trust and confidence in that service by placing restrictions on what municipal employees may do on the job, after hours, and after leaving public service, as described below. The sections referenced below are sections of G.L. c. 268A.

When the Commission determines that the conflict of interest law has been violated, it can impose a civil penalty of up to $10,000 ($25,000 for bribery cases) for each violation. In addition, the Commission can order the violator to repay any economic advantage he gained by the violation, and to make restitution to injured third parties. Violations of the conflict of interest law can also be prosecuted criminally.

I. Are you a municipal employee for conflict of interest law purposes?

You do not have to be a full-time, paid municipal employee to be considered a municipal employee for conflict of interest purposes. Anyone performing services for a city or town or holding a municipal position, whether paid or unpaid, including full- and part-time municipal employees, elected officials, volunteers, and consultants, is a municipal employee under the conflict of interest law. An employee of a private firm can also be a municipal employee, if the private firm has a contract with the city or town and the employee is a “key employee” under the contract, meaning the town has specifically contracted for her services. The law also covers private parties who engage in impermissible dealings with municipal employees, such as offering bribes or illegal gifts.
II. On-the-job restrictions.

(a) Bribes. Asking for and taking bribes is prohibited. (See Section 2)

A bribe is anything of value corruptly received by a municipal employee in exchange for the employee being influenced in his official actions. Giving, offering, receiving, or asking for a bribe is illegal.

Bribes are more serious than illegal gifts because they involve corrupt intent. In other words, the municipal employee intends to sell his office by agreeing to do or not do some official act, and the giver intends to influence him to do so. Bribes of any value are illegal.

(b) Gifts and gratuities. Asking for or accepting a gift because of your official position, or because of something you can do or have done in your official position, is prohibited. (See Sections 3, 23(b)(2), and 26)

Municipal employees may not accept gifts and gratuities valued at $50 or more given to influence their official actions or because of their official position. Accepting a gift intended to reward past official action or to bring about future official action is illegal, as is giving such gifts. Accepting a gift given to you because of the municipal position you hold is also illegal. Meals, entertainment event tickets, golf, gift baskets, and payment of travel expenses can all be illegal gifts if given in connection with official action or position, as can anything worth $50 or more. A number of smaller gifts together worth $50 or more may also violate these sections.

Example of violation: A town administrator accepts reduced rental payments from developers.

Example of violation: A developer offers a ski trip to a school district employee who oversees the developer’s work for the school district.

Regulatory exemptions. There are situations in which a municipal employee’s receipt of a gift does not present a genuine risk of a conflict of interest, and may in fact advance the public interest. The Commission has created exemptions permitting giving and
receiving gifts in these situations. One commonly used exemption permits municipal employees to accept payment of travel-related expenses when doing so advances a public purpose. Another commonly used exemption permits municipal employees to accept payment of costs involved in attendance at educational and training programs. Other exemptions are listed on the Commission’s website.

*Example where there is no violation:* A fire truck manufacturer offers to pay the travel expenses of a fire chief to a trade show where the chief can examine various kinds of firefighting equipment that the town may purchase. The chief fills out a disclosure form and obtains prior approval from his appointing authority.

*Example where there is no violation:* A town treasurer attends a two-day annual school featuring multiple substantive seminars on issues relevant to treasurers. The annual school is paid for in part by banks that do business with town treasurers. The treasurer is only required to make a disclosure if one of the sponsoring banks has official business before her in the six months before or after the annual school.

(c) **Misuse of position. Using your official position to get something you are not entitled to, or to get someone else something they are not entitled to, is prohibited. Causing someone else to do these things is also prohibited. (See Sections 23(b)(2) and 26)**

A municipal employee may not use her official position to get something worth $50 or more that would not be properly available to other similarly situated individuals. Similarly, a municipal employee may not use her official position to get something worth $50 or more for someone else that would not be properly available to other similarly situated individuals. Causing someone else to do these things is also prohibited.

*Example of violation:* A full-time town employee writes a novel on work time, using her office computer, and directing her secretary to proofread the draft.

*Example of violation:* A city councilor directs subordinates to drive the councilor’s wife to and from the grocery store.

*Example of violation:* A mayor avoids a speeding ticket by asking the police officer who stops him, “Do you know who I am?” and showing his municipal I.D.
(d) Self-dealing and nepotism. Participating as a municipal employee in a matter in which you, your immediate family, your business organization, or your future employer has a financial interest is prohibited. (See Section 19)

A municipal employee may not participate in any particular matter in which he or a member of his immediate family (parents, children, siblings, spouse, and spouse’s parents, children, and siblings) has a financial interest. He also may not participate in any particular matter in which a prospective employer, or a business organization of which he is a director, officer, trustee, or employee has a financial interest. Participation includes discussing as well as voting on a matter, and delegating a matter to someone else.

A financial interest may create a conflict of interest whether it is large or small, and positive or negative. In other words, it does not matter if a lot of money is involved or only a little. It also does not matter if you are putting money into your pocket or taking it out. If you, your immediate family, your business, or your employer have or has a financial interest in a matter, you may not participate. The financial interest must be direct and immediate or reasonably foreseeable to create a conflict. Financial interests which are remote, speculative or not sufficiently identifiable do not create conflicts.

*Example of violation:* A school committee member’s wife is a teacher in the town’s public schools. The school committee member votes on the budget line item for teachers’ salaries.

*Example of violation:* A member of a town affordable housing committee is also the director of a non-profit housing development corporation. The non-profit makes an application to the committee, and the member/director participates in the discussion.

*Example:* A planning board member lives next door to property where a developer plans to construct a new building. Because the planning board member owns abutting property, he is presumed to have a financial interest in the matter. He cannot participate unless he provides the State Ethics Commission with an opinion from a qualified independent appraiser that the new construction will not affect his financial interest.

In many cases, where not otherwise required to participate, a municipal employee may comply with the law by simply not participating in the particular matter in which she has a financial interest. She need not give a reason for not participating.
There are several exemptions to this section of the law. An appointed municipal employee may file a written disclosure about the financial interest with his appointing authority, and seek permission to participate notwithstanding the conflict. The appointing authority may grant written permission if she determines that the financial interest in question is not so substantial that it is likely to affect the integrity of his services to the municipality. Participating without disclosing the financial interest is a violation. Elected employees cannot use the disclosure procedure because they have no appointing authority.

**Example where there is no violation:** An appointed member of the town zoning advisory committee, which will review and recommend changes to the town’s by-laws with regard to a commercial district, is a partner at a company that owns commercial property in the district. Prior to participating in any committee discussions, the member files a disclosure with the zoning board of appeals that appointed him to his position, and that board gives him a written determination authorizing his participation, despite his company’s financial interest. There is no violation.

There is also an exemption for both appointed and elected employees where the employee’s task is to address a matter of general policy and the employee’s financial interest is shared with a substantial portion (generally 10% or more) of the town’s population, such as, for instance, a financial interest in real estate tax rates or municipal utility rates.

**Regulatory exemptions.** In addition to the statutory exemptions just mentioned, the Commission has created several regulatory exemptions permitting municipal employees to participate in particular matters notwithstanding the presence of a financial interest in certain very specific situations when permitting them to do so advances a public purpose. There is an exemption permitting school committee members to participate in setting school fees that will affect their own children if they make a prior written disclosure. There is an exemption permitting town clerks to perform election-related functions even when they, or their immediate family members, are on the ballot, because clerks’ election-related functions are extensively regulated by other laws. There is also an exemption permitting a person serving as a member of a municipal board pursuant to a legal requirement that the board have members with a specified affiliation to participate fully in determinations of general policy by the board, even if the entity with which he is affiliated has a financial interest in the matter. Other exemptions are listed in the Commission’s regulations, available on the Commission’s website.
Example where there is no violation: A municipal Shellfish Advisory Board has been created to provide advice to the Board of Selectmen on policy issues related to shellfishing. The Advisory Board is required to have members who are currently commercial fishermen. A board member who is a commercial fisherman may participate in determinations of general policy in which he has a financial interest common to all commercial fishermen, but may not participate in determinations in which he alone has a financial interest, such as the extension of his own individual permits or leases.

(e) False claims. Presenting a false claim to your employer for a payment or benefit is prohibited, and causing someone else to do so is also prohibited. (See Sections 23(b)(4) and 26)

A municipal employee may not present a false or fraudulent claim to his employer for any payment or benefit worth $50 or more, or cause another person to do so.

Example of violation: A public works director directs his secretary to fill out time sheets to show him as present at work on days when he was skiing.

(f) Appearance of conflict. Acting in a manner that would make a reasonable person think you can be improperly influenced is prohibited. (See Section 23(b)(3))

A municipal employee may not act in a manner that would cause a reasonable person to think that she would show favor toward someone or that she can be improperly influenced. Section 23(b)(3) requires a municipal employee to consider whether her relationships and affiliations could prevent her from acting fairly and objectively when she performs her duties for a city or town. If she cannot be fair and objective because of a relationship or affiliation, she should not perform her duties. However, a municipal employee, whether elected or appointed, can avoid violating this provision by making a public disclosure of the facts. An appointed employee must make the disclosure in writing to his appointing official.

Example where there is no violation: A developer who is the cousin of the chair of the conservation commission has filed an application with the commission. A reasonable person could conclude that the chair might favor her cousin. The chair files a written disclosure with her appointing authority explaining her relationship with her cousin prior
to the meeting at which the application will be considered. There is no violation of Sec. 23(b)(3).

(g) Confidential information. Improperly disclosing or personally using confidential information obtained through your job is prohibited. (See Section 23(c))

Municipal employees may not improperly disclose confidential information, or make personal use of non-public information they acquired in the course of their official duties to further their personal interests.

III. After-hours restrictions.

(a) Taking a second paid job that conflicts with the duties of your municipal job is prohibited. (See Section 23(b)(1))

A municipal employee may not accept other paid employment if the responsibilities of the second job are incompatible with his or her municipal job.

Example: A police officer may not work as a paid private security guard in the town where he serves because the demands of his private employment would conflict with his duties as a police officer.

(b) Divided loyalties. Receiving pay from anyone other than the city or town to work on a matter involving the city or town is prohibited. Acting as agent or attorney for anyone other than the city or town in a matter involving the city or town is also prohibited whether or not you are paid. (See Sec. 17)

Because cities and towns are entitled to the undivided loyalty of their employees, a municipal employee may not be paid by other people and organizations in relation to a matter if the city or town has an interest in the matter. In addition, a municipal employee may not act on behalf of other people and organizations or act as an attorney for other people and organizations in which the town has an interest. Acting as agent includes contacting the municipality in person, by phone, or in writing; acting as a liaison; providing documents to the city or town; and serving as spokesman.
A municipal employee may always represent his own personal interests, even before his own municipal agency or board, on the same terms and conditions that other similarly situated members of the public would be allowed to do so. A municipal employee may also apply for building and related permits on behalf of someone else and be paid for doing so, unless he works for the permitting agency, or an agency which regulates the permitting agency.

**Example of violation:** A full-time health agent submits a septic system plan that she has prepared for a private client to the town’s board of health.

**Example of violation:** A planning board member represents a private client before the board of selectmen on a request that town meeting consider rezoning the client’s property.

While many municipal employees earn their livelihood in municipal jobs, some municipal employees volunteer their time to provide services to the town or receive small stipends. Others, such as a private attorney who provides legal services to a town as needed, may serve in a position in which they may have other personal or private employment during normal working hours. In recognition of the need not to unduly restrict the ability of town volunteers and part-time employees to earn a living, the law is less restrictive for “special” municipal employees than for other municipal employees.

The status of “special” municipal employee has to be assigned to a municipal position by vote of the board of selectmen, city council, or similar body. A position is eligible to be designated as “special” if it is unpaid, or if it is part-time and the employee is allowed to have another job during normal working hours, or if the employee was not paid for working more than 800 hours during the preceding 365 days. It is the position that is designated as “special” and not the person or persons holding the position. Selectmen in towns of 10,000 or fewer are automatically “special”; selectman in larger towns cannot be “specials.”

If a municipal position has been designated as “special,” an employee holding that position may be paid by others, act on behalf of others, and act as attorney for others with respect to matters before municipal boards other than his own, provided that he has not officially participated in the matter, and the matter is not now, and has not within the past year been, under his official responsibility.
Example: A school committee member who has been designated as a special municipal employee appears before the board of health on behalf of a client of his private law practice, on a matter that he has not participated in or had responsibility for as a school committee member. There is no conflict. However, he may not appear before the school committee, or the school department, on behalf of a client because he has official responsibility for any matter that comes before the school committee. This is still the case even if he has recused himself from participating in the matter in his official capacity.

Example: A member who sits as an alternate on the conservation commission is a special municipal employee. Under town by-laws, he only has official responsibility for matters assigned to him. He may represent a resident who wants to file an application with the conservation commission as long as the matter is not assigned to him and he will not participate in it.

(c) Inside track. Being paid by your city or town, directly or indirectly, under some second arrangement in addition to your job is prohibited, unless an exemption applies. (See Section 20)

A municipal employee generally may not have a financial interest in a municipal contract, including a second municipal job. A municipal employee is also generally prohibited from having an indirect financial interest in a contract that the city or town has with someone else. This provision is intended to prevent municipal employees from having an “inside track” to further financial opportunities.

Example of violation: Legal counsel to the town housing authority becomes the acting executive director of the authority, and is paid in both positions.

Example of violation: A selectman buys a surplus truck from the town DPW.

Example of violation: A full-time secretary for the board of health wants to have a second paid job working part-time for the town library. She will violate Section 20 unless she can meet the requirements of an exemption.

Example of violation: A city councilor wants to work for a non-profit that receives funding under a contract with her city. Unless she can satisfy the requirements of an exemption under Section 20, she cannot take the job.
There are numerous exemptions. A municipal employee may hold multiple unpaid or elected positions. Some exemptions apply only to special municipal employees. Specific exemptions may cover serving as an unpaid volunteer in a second town position, housing-related benefits, public safety positions, certain elected positions, small towns, and other specific situations. Please call the Ethics Commission's Legal Division for advice about a specific situation.

IV. After you leave municipal employment. (See Section 18)

(a) **Forever ban.** After you leave your municipal job, you may never work for anyone other than the municipality on a matter that you worked on as a municipal employee.

If you participated in a matter as a municipal employee, you cannot ever be paid to work on that same matter for anyone other than the municipality, nor may you act for someone else, whether paid or not. The purpose of this restriction is to bar former employees from selling to private interests their familiarity with the facts of particular matters that are of continuing concern to their former municipal employer. The restriction does not prohibit former municipal employees from using the expertise acquired in government service in their subsequent private activities.

*Example of violation:* A former school department employee works for a contractor under a contract that she helped to draft and oversee for the school department.

(b) **One year cooling-off period.** For one year after you leave your municipal job you may not participate in any matter over which you had official responsibility during your last two years of public service.

Former municipal employees are barred for one year after they leave municipal employment from personally appearing before any agency of the municipality in connection with matters that were under their authority in their prior municipal positions during the two years before they left.

*Example:* An assistant town manager negotiates a three-year contract with a company. The town manager who supervised the assistant, and had official responsibility for the contract but did not participate in negotiating it, leaves her job to work for the
company to which the contract was awarded. The former manager may not call or write
the town in connection with the company’s work on the contract for one year after
leaving the town.

A former municipal employee who participated as such in general legislation on
expanded gaming and related matters may not become an officer or employee of, or
acquire a financial interest in, an applicant for a gaming license, or a gaming licensee, for
one year after his public employment ceases.

(c) Partners. Your partners will be subject to restrictions while you serve as a municipal employee and after your municipal service ends.

Partners of municipal employees and former municipal employees are also subject to
restrictions under the conflict of interest law. If a municipal employee participated in a
matter, or if he has official responsibility for a matter, then his partner may not act on
behalf of anyone other than the municipality or provide services as an attorney to anyone
but the city or town in relation to the matter.

Example: While serving on a city’s historic district commission, an architect reviewed
an application to get landmark status for a building. His partners at his architecture firm
may not prepare and sign plans for the owner of the building or otherwise act on the
owner’s behalf in relation to the application for landmark status. In addition, because the
architect has official responsibility as a commissioner for every matter that comes before
the commission, his partners may not communicate with the commission or otherwise act
on behalf of any client on any matter that comes before the commission during the time
that the architect serves on the commission.

Example: A former town counsel joins a law firm as a partner. Because she litigated a
lawsuit for the town, her new partners cannot represent any private clients in the lawsuit
for one year after her job with the town ended.

* * * * *

This summary is not intended to be legal advice and, because it is a summary, it does not
mention every provision of the conflict law that may apply in a particular situation. Our
website, http://www.mass.gov/ethics, contains further information about how the law
applies in many situations. You can also contact the Commission’s Legal Division via
our website, by telephone, or by letter. Our contact information is at the top of this document.

Version 6: Revised May 10, 2013

ACKNOWLEDGMENT OF RECEIPT

I, ____________________________, an employee at ____________________________,

(first and last name) (name of municipal dept.)

hereby acknowledge that I received a copy of the summary of the conflict of interest law
for municipal employees, revised May 10, 2013, on ____________________________.

(date)

Municipal employees should complete the acknowledgment of receipt and return it to the
individual who provided them with a copy of the summary. Alternatively, municipal
employees may send an e-mail acknowledging receipt of the summary to the individual
who provided them with a copy of it.
TOWN OF SANDWICH

HEALTH INSURANCE ELECTION FORM

As an employee who is entitled to the benefits of health insurance in the Town of Sandwich, I hereby elect ONE of the THREE options listed below:

_______ At this time, I do not elect to have health insurance, however, I may elect to choose health insurance coverage during an open enrollment period in the future.

_______ I do elect to have health insurance and wish for it to commence the first day of my employment with the Town. I understand that this requires that my health insurance premiums to be doubled until caught up, to have immediate coverage.

_______ I do elect to have health insurance and wish for it to commence 30 days after my first date of employment.

_________________________  ________________________
Employee Signature                  Date

_________________________  ________________________
Treasurer's Office                   Date
**INFORMATION REGARDING INSURANCE PREMIUMS**

*NEW EMPLOYEES ACCEPTING HEALTH/DENTAL BENEFITS:*
Our premiums for our Health Insurance and Dental Insurance are paid a month in advance. Your deductions from your pay check in August are paying for your coverage for the month of September. If you are a new employee who is electing to have Insurance benefits, your premiums will be doubled until you are caught up on deductions. Depending on when your first pay falls; the beginning of the month or the middle of the month will determine how many times your premiums will/may be doubled. This goes for new employees electing to have Insurance premiums start the day of hire or 30 days out.

*21-PAY SCHOOL EMPLOYEES:*
Please note if you are a 21-pay employee who is electing to have Insurance benefits and the effective date is NOT July 1st your Insurance deductions will be deducted at the 26-pay deduction rate until the end of May. The first pay in June when our new rates take effect your rates will then change to the 21-pay deduction amount. For example: If you are coming on our plan during the month of September you will be charged your deductions at the 26-pay rate until the first pay of June you will then be charged the 21-pay deduction. Please see above for all new employees regarding health insurance premium deductions.
Employee Health Insurance Responsibility Disclosure Form

You are completing this form because you have declined to participate in your employer sponsored health insurance plan and/or have declined to participate in the employer's "Section 125 Cafeteria Plan" pre-tax purchasing arrangement. A Section 125 Plan is not health insurance; it is a way to purchase health insurance on a pre-tax basis. For information about affordable health insurance options, visit the Commonwealth Connector at <www.mahealthconnector.org>.

Employer: please complete this section. See reverse side for instructions.

Employer Name: TOWN OF SANDWICH
Employer D/B/A: 130 MAIN STREET
Employer Address: SANDWICH, MA 02563
City | State | ZIP Code:

1. Did you offer a "Section 125 Cafeteria Plan" to this employee? Yes ☑ No
2. Did you offer employer sponsored health insurance to this employee? Yes ☑ No
3. If you offered sponsored insurance to this employee, what is the dollar amount of the employee's portion of the monthly premium cost of the least expensive individual health plan offered by the employer to the employee? (If did not offer sponsored insurance, leave blank.) $214.43

Employees: please complete this section. See reverse side for Instructions.

Employee First Name
Employee Last Name
Middle Initial
Suffix (e.g., Sr., Jr.)

1. Did you accept your employer sponsored health insurance? Yes ☑ No ☐ None Offered ☐
2. Did you agree to use your employer's "Section 125 Cafeteria Plan" to purchase health insurance? Yes ☑ No ☐ None Offered ☐
3. Do you have other health insurance? Yes ☑ No ☐

Employee Affidavit

I hereby affirm, under penalties of perjury, that all the information provided herein is true to the best of my knowledge. I also understand that if I do not have health insurance I may be responsible for the full costs of all medical treatment, that I may forfeit all or a portion of my Massachusetts personal tax exemption and be subject to other penalties pursuant to M.G.L.c. 111M, that the Employee Health Insurance Responsibility Disclosure (HIRD) Form contains information that must be reported in my Massachusetts tax return, and that I am required to maintain a copy of the signed HIRD Form.

Employee Signature
Date (MM/DD/YY)

The employer must retain this document for three (3) years and make it available upon request to the Division of Health Care Finance and Policy and the Department of Revenue as required by state regulation 114.5 CMR 18.00.
<table>
<thead>
<tr>
<th>Group Insurance Plan</th>
<th>Individual</th>
<th>Town Share</th>
<th>26 Pays</th>
<th>Individual</th>
<th>Town Share</th>
<th>26 Pays</th>
<th>Individual</th>
<th>Town Share</th>
<th>26 Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Blue Freedom</td>
<td>$20.00</td>
<td>$22.00</td>
<td>$24.00</td>
<td>$30.00</td>
<td>$33.00</td>
<td>$36.00</td>
<td>$42.00</td>
<td>$45.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>Original Plan</td>
<td>$25.00</td>
<td>$28.00</td>
<td>$32.00</td>
<td>$37.00</td>
<td>$41.00</td>
<td>$46.00</td>
<td>$53.00</td>
<td>$58.00</td>
<td>$65.00</td>
</tr>
<tr>
<td>Enrollment Option 2</td>
<td>$30.00</td>
<td>$35.00</td>
<td>$42.00</td>
<td>$48.00</td>
<td>$55.00</td>
<td>$64.00</td>
<td>$75.00</td>
<td>$85.00</td>
<td>$100.00</td>
</tr>
<tr>
<td>Enrollment Option 5</td>
<td>$35.00</td>
<td>$42.00</td>
<td>$51.00</td>
<td>$60.00</td>
<td>$70.00</td>
<td>$82.00</td>
<td>$100.00</td>
<td>$120.00</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

**Note:** 21 Pays will only have health insurance deducted 15 times.

**Monthly Group Insurance Deductibles:**

- **100%**
- **75%**
- **50%**
BOSTON MUTUAL LIFE INSURANCE COMPANY
1-800-669-2668 x700
120 Reayl Street • Canton, MA 02021

PLEASE PRINT OR TYPE

Town of Sandwich

Employee/Policyholder

Last, First, Middle

Tax Address (Street, City, State, Zip)

Gender (M/F) Occupation or Job Title Date of Birth Age

PAYROLL Weekly Bi-Weekly

Type Monthly Annual Earnings

Average Hours Worked Date of Hire or Date of Full Time Employment if different Effective Date State City

Spouse (Last, First, Middle)

You Must Have Basic Coverage to Elect Voluntary Coverage

BASIC:

Group # 27091 Div.

LIFE & AD&D

NO $ 2,000.00

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:

Group # Div.

LIFE & AD&D

SPOUSE

DEPENDENT LIFE:

CHILD(REN)

Name of Your Beneficiary for Life & AD&D

Beneficiary for Dependent Life:

Primary Beneficiary

Residential Address

Date of Birth

Social Security #

Rel. #

Relationship

% of Benefit

Yes/No

$500.00

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

Acceptance of Insurance

Employee Signature Required

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work. I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee

Date

Refusal of Insurance

Employee Name

Last, First, Middle

Employee/Policyholder

Group No.

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer for the Association with whom I am affiliated and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

Basic Life & AD&D Voluntary Life & AD&D Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee

Date

Signature of Witness

Date

PY 240-J23 9/13
Plan Options

Medical

Blue Care Elect $300 Deductible
View Summary

Network Blue NE $300 Deductible
View Summary

Dental

Dental Blue Freedom

Helpful Resources

Plan Info

Emergency Room Alternatives
Telehealth Brochure
Dental Accumulated Maximum Rollover
Enhanced Dental Benefits
Enhanced Dental Benefit Enrollment Form
Dental Blue Freedom Fact Sheet
Nurse Hotline
2019 Fitness Reimbursement $150
2019 Weight Loss Reimbursement $150
Blue Card Program Brochure
Commitment To Confidentiality
How To Choose A PCP
MyBlue App
Member Identity Protection Services
SmartShopper®
Smart90
Mail Service Pharmacy Brochure & Form
S9 Generic Medications List
2019 Pharmacy Formulary
3-Tier Pharmacy Program
S9 Generics Program Fact Sheet
Group Voluntary Life and Accidental Death & Dismemberment Benefit Summary for Eligible Employees of Town of Sandwich

Eligibility
You as an active full-time employee working 20 or more hours per week, your spouse under age 70, your unmarried children ages 14 days to 19 years (to age 25 if a full-time student), and handicapped children over the age of 19 are eligible for coverage.

Dependents may not be insured if they are confined in a medical facility. Dependent coverage is available only if you, the employee, also elects coverage. If you are not actively at work on the effective date of coverage, then your insurance will not become effective until the date you return to active employment.

Voluntary Life and AD&D Available Benefit Amounts
- You have the flexibility to choose coverage for yourself in units of $10,000 to a maximum of $300,000. However, the maximum coverage amount you may elect cannot exceed five times your base annual salary.
- You may insure your spouse in units of $5,000 to a maximum of $100,000, not to exceed 50% of your coverage amount.
- You may insure your dependent children for Life Insurance only. Coverage amounts are as follows:
  Option 1
  14 days to 1 year..............................................$500
  1 year to 19 years*..........................................$5,000
  *(Age 25 for full-time students)
  Option 2
  14 days to 1 year..............................................$1,000
  1 year to 19 years*..........................................$10,000
  *(Age 25 for full-time students)

A spouse or child who is also an employee cannot be insured as a dependent. If both spouses are insured employees of the same group, their children can be insured as dependents of one spouse only.

Medical Questions
If you and your eligible dependents enroll within the initial eligibility period as defined by the policy, you and your spouse may purchase a specific amount of insurance on a guaranteed basis. No medical questions will be asked for coverage at or under the Guarantee Issue Amount.

Guarantee Issue Amounts

<table>
<thead>
<tr>
<th>Age</th>
<th>Employee</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Age 60</td>
<td>$100,000</td>
<td>$50,000</td>
</tr>
<tr>
<td>Age 60-69</td>
<td>$40,000</td>
<td>$20,000</td>
</tr>
<tr>
<td>*Age 70 and over</td>
<td>$30,000</td>
<td>Not Eligible</td>
</tr>
</tbody>
</table>

All life coverage for dependent children is Guarantee Issue

* Employee's Insurance reduction schedule applies. Please refer to the section: Benefit Reductions

Guarantee issue coverage will become effective for eligible employees on the later of the effective date as defined by the group policy or the date the application is approved by Boston Mutual. Proof of good health satisfactory to Boston Mutual is required for amounts above the Guarantee Issue Amounts or beyond the initial eligibility period.

Cost of Coverage
You pay for the cost of the Group Voluntary Term Life and AD&D coverage. Below, you will find samples of Monthly payroll deductions for you and your spouse:

<table>
<thead>
<tr>
<th>Sample Monthly Payroll Deductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>&lt;35</td>
</tr>
<tr>
<td>35-39</td>
</tr>
<tr>
<td>40-44</td>
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<tr>
<td>45-49</td>
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<tr>
<td>50-54</td>
</tr>
<tr>
<td>55-59</td>
</tr>
<tr>
<td>60-64</td>
</tr>
<tr>
<td>65-69</td>
</tr>
<tr>
<td>70+</td>
</tr>
</tbody>
</table>

This plan utilizes Boston Mutual's Issue Age billing option. Issue age billing means that Employees and Spouses enroll and are billed based on their age band as of the effective date of coverage. Once enrolled, Employees and Spouses remain in the age band they were originally issued at with Boston Mutual.

After the initial rate guarantee period, the group is subject to an annual review and possible rate changes:

- The cost to insure all eligible dependent children for Voluntary Life Insurance is only:
  Option 1: $0.95 per $5,000 Family Unit Monthly
  Option 2: $1.90 per $10,000 Family Unit Monthly

See reverse side for additional information.


Benefit Reductions

- Your Group Voluntary Life insurance reduces upon the attainment of age 70 and periodically thereafter in accordance with the following schedule:
  - To 65% of the original benefit at age 76;
  - To 50% of the original benefit at age 75;
  - To 35% of the original benefit at age 80;
  - To 25% of the original benefit at age 85;
  - To 20% of the original benefit at age 90;
  - To 15% of the original benefit at age 95.

- Your spouse’s insurance terminates upon the attainment of age 70.

- Dependent Children coverage terminates upon notice to Boston Mutual that all dependent children are no longer eligible.

  All insurance benefits shall terminate upon the employee’s retirement.

Applying for coverage

Complete the provided enrollment form. When you sign it, you are giving your employer authorization to deduct the premiums from your pay. We will process your application quickly. Boston Mutual will notify you of the effective date of insurance for requests that are approved for coverage in excess of the Guaranteed Issue amount.

Additional Features

Group Voluntary Accidental Death & Dismemberment

The Group Voluntary Life Insurance benefit is doubled if death is due to an accident. Dismemberment benefits are payable for loss of eyesight or limbs according to the policy provisions. Group Voluntary AD&D is only available for employees and their spouses.

Portability

If you leave your employment prior to age 60, the coverage is “portable” for you, your spouse under age 60 and all eligible dependent children. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium or Group Voluntary AD&D.

Conversion

Employees have 31 days from the date of termination to convert their Group Voluntary Life Insurance to an individual permanent life policy without evidence of insurability. The premium will be based on Boston Mutual’s usual rate for the insured’s age on the date of conversion. Coverage will not include Waiver of Premium or Group Voluntary AD&D.

Waiver of Premium

If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Accelerated Death Benefit

This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary.

Education Benefit

We will pay a percentage of an employee’s Group Voluntary Life Insurance benefit to a maximum of $2,500 per year, for up to four years of education, to each qualifying dependent if the employee’s death is the result of an accident while covered under Group Voluntary AD&D.

Seat Belt Benefit

We will pay an additional 50% of the Group Voluntary AD&D benefit, not to exceed $10,000, in the event of an insured’s death as a result of an automobile accident while wearing a properly secured seat belt.

Repatriation of Remains Benefit

If an employee dies as a result of an Accident while insured for Group Voluntary AD&D and the death occurs outside a 100 mile radius from his or her primary residence, we will pay for Covered Expenses reasonably incurred to return his or her body to their primary residence up to $5,000.

Exclusions

Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: suicide or attempted suicide; intentionally self-inflicted injuries; insurrection, riot or war; diseases, or medical treatment for diseases; poison or bacterial infection; accident while serving on active duty in the armed forces; travel or flight in any aircraft or vehicle which can fly above the earth’s surface (as detailed in the policy); commission of an assault or felony by an insured; the insured’s intoxication or voluntary use of any drug, unless taken as prescribed by a physician; voluntary taking or inhalation of poison, gas, or flames; or injury which occurred before the effective date of the insured’s coverage under this policy. All exclusion details are stated in the matter policy and certificate which may be reviewed through your benefit administrator.

Also available to you...

Bereavement Counseling*

This service is provided to all beneficiaries who experience the loss of a loved one. Beneficiaries have access to a toll-free counseling service supported by professional counselors experienced with the human emotions associated with the death of a loved one.

*Services provided by Health Management Systems of America—a nationally recognized leader in the field of Mental and Behavioral Health Care Services. These services are currently available but are not part of your Boston Mutual policy/contract.
Town of Sandwich

Employee/Policymaker

Payroll:  □ Weekly  □ Bi-Weekly

Occupation or Job Title

PAYROLL:  □ Weekly  □ Bi-Weekly

Date of Birth

Effective Date

Gender (M/F)

Marital Status

Spouse (Last, First, Middle)

Date of Birth

Age

No. of Dependents

Average Hours Worked

or Date of Full Time Employment if different

You Must Have Basic Coverage to Elect Voluntary Coverage

You Must Have Voluntary Coverage to Elect Dependent Coverage

LIFE & AD&D

Insurance Amount

Group # __________ Div.

Group # 27091 Div.

Yes  No

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: (List Insured's Full Name and Relationship)

Primary Beneficiary(ies):

Residential Address

Date of Birth

Social Security #

Voluntary:

Insurance Amount

Monthly

Permanent

Annual

Earnings $:

Date

Relationship

% of Benefit

BENEFICIARY

If you designate more than one beneficiary, please make the total percentages of benefit equal 100%.

If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

ACCEPTANCE OF INSURANCE - Employer Signature Required

I agree for the insurance of which I am now eligible (or for which I may become eligible) under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work. I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee

Date

REFUSAL OF INSURANCE

Employee Name ______________

Employee/Policymaker

Group No.

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer (or the Association with which I am affiliated) and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

□ Basic Life & AD&D

□ Voluntary Life & AD&D

□ Dependents Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee

Date

Signature of Witness

Date
**BOSTON MUTUAL LIFE INSURANCE COMPANY**

[120 Royall Street • Canton, MA 02021 1-800-669-2668 Ext. 473]

**STATEMENT OF INSURABILITY FORM FOR GROUP INSURANCE**

To be completed for all proposed insureds who are applying for more than the guaranteed issue limit or are completing the form 31 or more days from the date that the proposed insureds became eligible.

Refer to the Group Policy for types of coverage available and eligible amounts of insurance.

<table>
<thead>
<tr>
<th>Group #</th>
<th>Div. #</th>
<th>Employer/Group Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>27091</td>
<td></td>
<td>Town of Sandwich</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security #</th>
<th>Employee Name (Last, First, Middle Initial)</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Telephone #</th>
<th>Address</th>
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</table>

**PROPOSED INSURED(S)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Height</th>
<th>Weight (if pregnant, re-insurance / wt. / in)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**REASON**

<table>
<thead>
<tr>
<th>NEW</th>
<th>CHANGE</th>
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<tbody>
<tr>
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</tbody>
</table>

**INSURANCE**

<table>
<thead>
<tr>
<th>YOU</th>
<th>[LIFE]</th>
<th>AD&amp;D</th>
<th>VOLUNTARY LIFE</th>
<th>VOLUNTARY AD&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Insurance Requested</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total New Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Short Term Disability $ Weekly Benefit]</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>[Long Term Disability $ Monthly Benefit]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YOUR SPOUSE</th>
<th>[LIFE]</th>
<th>AD&amp;D</th>
<th>VOLUNTARY LIFE</th>
<th>VOLUNTARY AD&amp;D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Insurance Requested</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Total New Coverage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Other $ |

 ICCI7 GRP-EVID 9/17

220-004 ICC 9/17
**Evidence of Insurability**

Please list all life insurance and/or annuity contacts now in-force or pending on your life.

<table>
<thead>
<tr>
<th>Existing Coverage</th>
<th>Name of Company (if replacement include Policy No.)</th>
<th>Life Amount</th>
<th>AD&amp;D Amount</th>
<th>Year Issued or Pending</th>
<th>Do you intend to replace or change this coverage if you and your dependents are approved for the insurance applied for on this application?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Employee</strong> ☐ YES ☐ NO</td>
<td></td>
<td></td>
<td></td>
<td>☐ YES ☐ NO</td>
</tr>
<tr>
<td></td>
<td><strong>Spouse</strong> ☐ YES ☐ NO</td>
<td></td>
<td></td>
<td></td>
<td>☐ YES ☐ NO</td>
</tr>
</tbody>
</table>

**To be Completed for ALL Proposed Insureds if Required by the Group Insurance Contract**

1. Have you used any form of tobacco products (cigarettes, pipe, cigars, chewing tobacco, nicotine gum or patches) within the past 12 months? **Employee ☐ YES ☐ NO Spouse ☐ YES ☐ NO**

2. In the past [3-10 years], have ANY of the proposed insureds been diagnosed, treated, tested positive for or been given medical advice by a licensed medical professional that they had: A) sleep apnea, asthma or emphysema; B) high blood pressure, stroke, chest pain, transient ischemic attack (TIA), heart or circulatory disease or disorder; C) intestinal disease or disorder or ulcer; D) diabetes; E) leukemia, cancer, tumor or malignancy; F) epilepsy, mental or nervous disease or disorder; G) kidney or genitourinary disease or disorder; H) disorder of the back, muscles, bones or joints; I) liver disease or disorder; J) pancreatitis (new or acute); or K) thyroid disorder? ☐ YES ☐ NO

3. In the past 5 years, have ANY of the proposed insureds been treated for or been diagnosed by a licensed medical professional as having an immune deficiency disorder or AIDS (Acquired Immune Deficiency Syndrome)? ☐ YES ☐ NO

4. In the past 5 years, have ANY of the proposed insureds: 1) been hospitalized or had hospitalization recommended; 2) had a physical examination or medical test with other than normal results? ☐ YES ☐ NO

5. Within the next 2 years, do you or your spouse: A) fly, or intend to fly, as pilot or crew member; B) race or test drive any form of vehicle; C) scuba dive; D) hang glide or sky dive? ☐ YES ☐ NO

6. Have ANY of the proposed insured, within the past [3-10 years], used or are they currently using or received treatment or consultation for the use of heroin, morphine, other narcotics, marijuana, barbiturates, amphetamines or hallucinogenic drugs or alcoholism? ☐ YES ☐ NO

7. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having memory loss? ☐ YES ☐ NO

8. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Amyotrophic Lateral Sclerosis (ALS)? ☐ YES ☐ NO

9. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having autism? ☐ YES ☐ NO

10. In the past 2 years, have ANY of the proposed insureds been treated, examined or advised by a licensed medical professional for attempted suicide? ☐ YES ☐ NO

11. In the past [3-10 years], have ANY of the proposed insureds been diagnosed by a licensed medical professional as having Huntington’s Chorea? ☐ YES ☐ NO

**To be Completed if Applying for Disability Insurance**

12. Are ANY of the proposed insureds currently pregnant? ☐ YES ☐ NO

Details for questions [2-12] answered "YES". Include question number. *(Attach additional details on a signed and dated separate sheet)*

<table>
<thead>
<tr>
<th>Name</th>
<th>Medical Condition</th>
<th>Date(s)</th>
<th>Details/Treatment</th>
<th>Name &amp; Address of Attending Physicians and Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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AUTHORIZATION TO OBTAIN INFORMATION

MIB PRE-NOTICE
Information regarding your insurability will be treated as confidential. Boston Mutual Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. (formerly known as Medical Information Bureau, Inc.), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information in your file. Please contact MIB, Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

MIB REPORTING AUTHORIZATION
I authorize Boston Mutual Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

CONSUMER REPORTING AUTHORIZATION
I authorize Boston Mutual Life Insurance Company to obtain a Consumer Report, which may include a report from MIB, Inc. (formerly Medical Information Bureau, Inc.) on me. I understand that information concerning my application for coverage may be verified through one or more of these reports and that information received through this process may be used in whole or in part to determine my eligibility for coverage. If the use of a Consumer Report results in an adverse action regarding my application for coverage, I will be informed by Boston Mutual of my rights, concerning that action.

REPRESENTATIONS AND NOTICE TO APPLICANTS

I/we have read the Statement of Insurability form and represent that the statements and answers are complete and true to the best of my/our knowledge and belief. I/we agree that this form shall form the basis for and become a part of the consideration for the insurance applied for.

CAUTION: Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured (Employee/Member)  Date  Signed & Dated at (City, State)

Signature of Proposed Insured (Other than Employee/Member) (Employees/Member if the proposed insured is under [15])  Date  Signed & Dated at (City, State)

MUST BE USED WITH HIPAA FORM DESIGNATED FOR YOUR STATE
BOSTON MUTUAL LIFE INSURANCE COMPANY
120 ROYALL STREET • CANTON, MASSACHUSETTS 02021 • 800-669-2668

Authorization for Release of Health-Related Information To BOSTON MUTUAL LIFE INSURANCE COMPANY
(This authorization complies with the HIPAA Privacy Rule)

Name of (Proposed) Insured/Patient (please print) ___________________________ Date of Birth __________

Name of Second (Proposed) Insured/Patient (please print) ___________________________ Date of Birth __________

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to the person named above, or on such person's behalf, to disclose the entire medical record and any other protected health information concerning such person to the Boston Mutual Life Insurance Company (BML) and its employees, representatives and reinsurers. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements such person has made to restrict protected health information do not apply to this authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that BML may: 1) write an application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage such person named above has or has applied for with BML.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to BML at 120 Royall Street, Canton, MA 02021, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of the Providers have relied on this Authorization or to the extent that BML has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and is no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that the Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release complete medical records, BML may not be able to process an application for coverage, or if coverage has been issued may not be able to make any benefit payments. I acknowledge that I have received a copy of BML's Notice of Information of Privacy Practices. I have read this authorization and understand that I or my authorized representative can receive a copy of it.

_________________________________________ __________________________
Signature of Proposed Insured/Claimant/Patient or Personal Representative Date

Description of Personal Representative’s Authority or Relationship to Proposed Insured/Claimant/Patient ___________________________

_________________________________________ __________________________
Signature of Second Proposed Insured/Claimant/Patient or Personal Representative Date

Description of Personal Representative’s Authority or Relationship to Second Proposed Insured/Claimant/Patient ___________________________

- DESIGNATION OF AUTHORIZED PERSONAL REPRESENTATIVE -

I, the undersigned, designate ___________________________ the beneficiary(ies) of this Boston Mutual Life Insurance policy, as my authorized personal representative(s) who, upon my death, may authorize the release of and may review all Protected Health Information relating to a claim against this policy. This designation will be void if I change my beneficiary(ies) or otherwise appoint another authorized personal representative.

_________________________________________ __________________________
Signature of Insured Date

HA-10.2013 andBML

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Voluntary Life Insurance

Payroll Withholding Amounts 26 Pays

Town of Sandwich