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STATE OF SOUTH CAROLINA

EMPLOYMENT APPLICATION

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Position applying for:

Job Title _____

Agency _____ Location _____

Contact Information

Name _____ Former Last Name _____
First *Middle Initial* *Last*

Mailing Address _____

Address _____
City *County* *State* *Zip Code*

Email Address _____

Home Phone _____ Alternate Phone _____ Notification Preference ☐ Mail ☐ Email

Other Personal Information

Do you possess a valid driver's license? ☐ Yes ☐ No If yes, provide State and number: _____

Expiration date _____ Class (check one) ☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ M ☐ G

Can you, after employment, submit proof of your legal right to work in the United States? ☐ Yes ☐ No _____
Month and Day of Birth

Are you willing to relocate? ☐ Yes ☐ No If yes, provide counties _____

What type of job are you looking for? ☐ Regular ☐ Temporary ☐ Seasonal ☐ Internship

What types of work will you accept? ☐ Full Time ☐ Part Time ☐ Per Diem

What shifts are you available to work? ☐ Day ☐ Evening ☐ Night ☐ Rotating ☐ Weekends ☐ On Call (as needed)

Education

High School Name _____ Location _____ ☐ Diploma ☐ Other (specify) _____

Give name and address of school, major course of study, and degree achieved.

Undergraduate College/University _____ Graduate School _____

Degree Attained _____ Degree Attained _____

Year _____ Year _____

Additional Information

Certificates and Licenses _____

_____

Additional Skills _____

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STATE OF SOUTH CAROLINA

EMPLOYMENT APPLICATION

Work History

Describe your work experience in detail, beginning with your current or most recent job. Include military service (indicate rank) and job related volunteer work, if applicable. Provide explanation for any gaps in employment. All information in this section must be complete. A résumé may be attached, but not substituted for completing this section. Should you need additional space, copy this page.

1. Name of Present or Last Employer: _____

Job Title: _____

Address: _____ Phone _____ Supervisor _____

From: ____/____/____ To: ____/____/____ Hours Per Week _____ Salary _____ Number Supervised ____

May we contact this employer? ☐ Yes ☐ No

Job Duties (give details) _____

_____

_____

Reason For Leaving _____

2. Your Next Most Recent Employer: _____

Job Title: _____

Address: _____ Phone _____ Supervisor _____

From: ____/____/____ To: ____/____/____ Hours Per Week _____ Salary _____ Number Supervised ____

May we contact this employer? ☐ Yes ☐ No

Job Duties (give details) _____

_____

_____

Reason For Leaving _____

3. Your Next Most Recent Employer: _____

Job Title: _____

Address: _____ Phone _____ Supervisor _____

From: ____/____/____ To: ____/____/____ Hours Per Week _____ Salary _____ Number Supervised ____

May we contact this employer? ☐ Yes ☐ No

Job Duties (give details) _____

_____

_____

Reason For Leaving _____

Application 3 of 3

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STATE OF SOUTH CAROLINA

EMPLOYMENT APPLICATION

Please carefully read the following information:

In addition to evaluating you for the position for which you are applying, the following questions will provide us with statistics needed to evaluate our recruitment program, as well as to prepare statistical reports required by Federal, State and local agencies.

Have you ever been convicted of a criminal offense? ☐ Yes ☐ No
Note: Omit minor vehicle violations and any offense committed before your 17th birthday, which was finally adjudicated in juvenile court or under a youthful offender law. Conviction of a criminal offense is not a bar to employment in all cases. Each conviction is evaluated individually.

If yes, please list charge(s)_____

Where Convicted _____ Date _____ Disposition/Status _____

Are you currently employed by the State of South Carolina? ☐ Yes ☐ No If yes, which agency? _____

Do you have any relatives employed with the State of South Carolina? ☐ Yes ☐ No If yes, please provide name(s), relationship, and agency below.

Name _____ Relationship _____ Agency _____

Name _____ Relationship _____ Agency _____

Have you ever been terminated or forced to resign from any job? ☐ Yes ☐ No If yes, please explain below.

_____

_____

Will you need reasonable accommodations to participate in the selection procedures (e.g., interview, written tests, or job demonstration)? ☐ Yes ☐ No

If yes, contact the human resources office of the agency for which you are applying.

State agencies are actively supporting the Family Independence Act by hiring welfare and food stamp recipients for certain jobs. Are you currently receiving AFDC benefits or food stamps? ☐ Yes ☐ No

Gender: ☐ Female ☐ Male Date of birth: ____/____/____ Social security number: ____-____-____

Ethnicity: ☐ American Indian / Alaska Native ☐ Asian ☐ Black / African American ☐ Hispanic / Latino
☐ Native Hawaiian / Other Pacific Islander ☐ Two or More Races ☐ White

Student Loan: State Law (59-111-50) prohibits employment with the State to people who have defaulted on certain student loans, unless they can prove that satisfactory arrangements have been made for repayment. By my signature, I certify that I am not currently in default on a student loan.

Have you been separated from South Carolina State Government employment as a part of a reduction-in-force within the past 12 months? ☐ Yes ☐ No

Signature_____ Date_____

Authority to Release Information: By my signature, I consent to the release of information to authorized officers, agents, and employees of the State of South Carolina which may include but not be limited to information concerning my past and present work; including my official personnel files; attendance records; evaluations; educational records including transcripts; military service; law enforcement records; and any personnel record deemed necessary. In addition, I consent to authorize appropriate officers, agents and employees of the State to make inquiries of third parties. I further release the organization, educational entity, present and former employers, law enforcement organization, all third parties from any and all claims of whatever nature that I may have as a result of any inquiry or response given to such inquiries made in connection with my application for employment.

Signature_____ Date_____

Certification of Applicant: By my signature, I affirm, agree, and understand that all statements on this form are true and accurate. Any misrepresentation, falsification, or material omission of information or data on this application may result in exclusion from further consideration or, if hired, termination of employment. If I have requested herein that my present employer not be contacted, an offer of employment may be conditioned upon acceptable information and verification from such employer prior to beginning work.

Signature_____ Date_____

Give the name, address, and phone number of two people, not relatives, who are familiar with your work.

Name _____ Address _____ Phone _____

Name _____ Address _____ Phone _____

Form W-4

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

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

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You're single and have only one job; or • You're married, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children. • If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.	G
H	Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ►	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4** — Department of the Treasury, Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial / Last name		2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		5
6 Additional amount, if any, you want withheld from each paycheck		6 $
7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		7

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Form W-4 2 of 2

Deductions and Adjustments Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $287,650 if you're head of household; $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,700 if married filing jointly or qualifying widow(er); $9,350 if head of household; $6,350 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2017 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2017 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note: Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note: If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $7,000	0	$0 - $8,000	0
7,001 - 14,000	1	8,001 - 16,000	1
14,001 - 22,000	2	16,001 - 26,000	2
22,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 70,000	5
44,001 - 55,000	6	70,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 95,000	10	140,001 and over	10
95,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $75,000	$610	$0 - $38,000	$610
75,001 - 135,000	1,010	38,001 - 85,000	1,010
135,001 - 205,000	1,130	85,001 - 185,000	1,130
205,001 - 360,000	1,340	185,001 - 400,000	1,340
360,001 - 405,000	1,420	400,001 and over	1,600
405,001 and over	1,600		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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

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

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

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

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

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

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

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

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

QR Code - Section 1
Do Not Write In This Space

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

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)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Form I-9 2 of 3

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

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.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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 Name

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)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(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.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Form 1102
Revised 7/6/2012
Page 1

Print or type in black ink

Please read the instructions on the reverse (Page 2) before completing this form.

ACTIVE MEMBER BENEFICIARY FORM

BENEFICIARY DESIGNATION, CONTINGENT BENEFICIARY FOR ACTIVE MEMBERS ONLY- RETIREES USE FORM 7201

SC Public Employee Benefit Authority
South Carolina Retirement Systems
P.O. Box 11960, Columbia, SC 29211-1960

Use for designation of active member beneficiaries and contingent beneficiaries. You may wish to consult with an attorney/estate planner before completing this form.

CHECK ONE:
☐ New Enrollee
☐ Change of Beneficiary

Retirement System (check one)
☐ SCRS ☐ PORS
☐ GARS ☐ JSRS

Section I **PERSONAL INFORMATION**

1. Last Name & Suffix	2. First/Middle Name	3. Social Security Number

4. Date of Birth	5. Address

6. City	7. State	8. ZIP+4

ALL SECTIONS MUST BE COMPLETED

Section II-A BENEFICIARY(IES) FOR REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS - I designate the following **PRIMARY** beneficiary(ies) to receive my Retirement Systems refund of contributions or survivor benefits if eligible.

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section II-B Contingent Beneficiaries Have No Rights Unless All Primary Beneficiaries Have Died - I designate the following **CONTINGENT** beneficiary(ies) to receive my Retirement Systems refund of contributions or applicable survivor benefits. **If the contingent beneficiary designation below is blank all previous contingent beneficiaries will be revoked and your estate will become your contingent beneficiary.**

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section III **BENEFICIARY(IES) FOR INCIDENTAL DEATH BENEFIT (You may not designate contingent beneficiaries for the Incidental Death Benefit). I designate the following beneficiary(ies) to receive my Retirement Systems Incidental Death Benefit:**

1. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
2. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship
3. Name of Beneficiary (ONE PERSON)	Social Security #	Sex ☐ M ☐ F	Date of Birth	Relationship

Section IV **CERTIFICATION AND CONDITIONS**

IMPORTANT: Please read the Certification and Conditions sections of the instructions on the reverse (Page 2) before signing this form. I hereby certify I have read and understand the information on the reverse (Page 2), including the certification and conditions, and I agree to the provisions stated.

MEMBER'S SIGNATURE _____ (Do not print) WITNESS _____ (Required only when signed by mark)

STATE OF _____ COUNTY OF _____

Acknowledged before me this date _____ NOTARY NAME _____

My Commission Expires _____ NOTARY SIGNATURE _____ (Out of state, requires Seal)

Active Beneficiary Form

2 of 2

INSTRUCTIONS

USE THIS FORM FOR ACTIVE MEMBER BENEFICIARY DESIGNATIONS WHICH DO NOT REQUIRE A TRUSTEE APPOINTMENT. THIS FORM MUST BE COMPLETED IN ITS ENTIRETY EACH TIME. AN ACKNOWLEDGMENT LETTER WILL BE SENT TO THE MEMBER EACH TIME A FORM IS RECEIVED BY THE SC RETIREMENT SYSTEMS. FOR RETIREE BENEFICIARY DESIGNATION, USE FORM 7201.

Check the appropriate boxes in the upper right corner. If you are a member of more than one system, complete a beneficiary form (FORM 1102) for each system. You should complete a form for each system of which you are a member when making any beneficiary changes (i.e. if you complete a FORM 1102 for your SCRS account, beneficiary changes will be for that system only, your prior designations for your PORS account would still be in effect).

SECTION I

1-8. Complete the general information concerning yourself.

SECTION II-A REFUND OF CONTRIBUTIONS/SURVIVOR BENEFITS

On this form you may designate a person(s) or your estate as beneficiary for your retirement contributions or survivor benefits. Leave the relationship, sex, date of birth, and SSN blank if you are naming your estate as beneficiary. If you are naming your estate as beneficiary, you may not designate a person(s) for this portion of your retirement benefits. If additional space is needed to designate more than three beneficiaries, complete and attach a second FORM 1102 and indicate on the form how many pages are being submitted. That information will assist the SC Retirement Systems in determining total number of forms submitted in the event the forms are separated during the processing. **If Section II-A is left blank the Form 1102 is incomplete. The Form 1102 is marked "VOID" and returned for completion of a new form.**

NOTE: SURVIVOR BENEFITS WILL NOT BE PAID TO AN ESTATE - LUMP SUM REFUND ONLY!

SECTION II-B CONTINGENT BENEFICIARY (OPTIONAL)

In accordance with §9-1-1650, §9-9-100, and §9-11-110, Code of Laws of SC (1976) as amended, an "active" member (a member who is actively employed, making regular contributions and earning service credit) may name contingent beneficiaries to receive a refund of member contributions or survivor benefits (if eligible). **{THESE CONTINGENT BENEFICIARIES HAVE NO RIGHTS, UNLESS ALL PRIMARY BENEFICIARIES HAVE DIED}.** Contingent beneficiaries may not be designated for Incidental Death Benefit. If you do not want a contingent beneficiary, write "NONE" in Section II-B on the reverse (Page 1) of this form. **If a form is received in which the contingent beneficiary section is left blank, the designation will default to estate, even if there is a prior contingent beneficiary designation on file.**

SECTION III INCIDENTAL DEATH BENEFIT

You may name different beneficiaries for the Incidental Death Benefit (a benefit equal to your annual salary), paid in a lump sum (if the employer has elected this coverage). The $3,000 State Life Insurance and Optional Life Insurance are administered by the Employee Insurance Program (EIP); contact EIP for information pertaining to those benefits. Contact your employer or the SC Retirement Systems for Incidental Death Benefit coverage. If you do not have Incidental Death Benefit coverage, write "N/A" in Section III on the reverse (Page 1) of this form.

SECTION IV CERTIFICATION AND CONDITIONS

1. **CERTIFICATION:** This form must be signed by the member in the presence of a notary public and be properly notarized. If more than one form is completed, **ALL** forms must be notarized on the same date. **FORMS ALTERED IN THE BENEFICIARY DESIGNATION OR CERTIFICATION SECTIONS WILL NOT BE ACCEPTED.**
2. **REVOCATION:** All previous beneficiary designations to receive retirement benefits are hereby revoked.
3. **AUTHORIZATION:** I hereby authorize the SC Retirement Systems to make payment of any refund of my accumulated contributions and/or any other payment due in the event of my death prior to retirement to the beneficiary(ies) designated on the front of this form (Page 1) in accordance with the provisions of the SC Retirement Systems , and agree on behalf of myself and my heirs and assigns, that any payment so made shall be a complete discharge of the claim or claims, and shall constitute a release of the Retirement Systems from any further obligations on account of the benefit or benefits. In the event my primary beneficiary(ies) predeceases me and if a contingent beneficiary designation is on file, the SC Retirement Systems would pay any benefits due to the contingent beneficiary(ies). In the event that no primary beneficiary(ies) or contingent beneficiary(ies) are alive at the time of my death, my estate (which is ineligible for survivor benefits), will automatically become my designated beneficiary. I reserve the right to change the designated beneficiary(ies) by a written designation filed with the SC Retirement Systems in accordance with its rules and regulations.
4. **PAYMENT:** The SC Retirement Systems shall be fully discharged of liability for all amounts paid to the beneficiary(ies), and shall have no other obligation as to the application of such amounts. In any dealing with a beneficiary(ies), including but not limited to any consent, release, or waiver of interest, the SC Retirement Systems shall be fully protected against the claim or claims of every other person.
5. **MULTIPLE BENEFICIARIES:** Survivor benefits payable to two or more beneficiaries shall be calculated based upon the average age of the designated beneficiaries. Payments will be equally divided among surviving beneficiaries at the member's death.

Please contact Customer Services with any questions: (803)737-6800, (800)868-9002 (within SC only) or www.retirement.sc.gov.

NOE

You must also complete a Tobacco Certification form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTIVE EMPLOYEE NOTICE OF ELECTION (NOE)

SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
INSURANCE BENEFITS

A
See Instructions - If Completing By Hand Use Black Ink

ACTION

Select One:	Type of Change	BA Use Only	MoneyPlus Pretax Premiums
☐ New Hire ☐ Transfer ☐ Change	☐ Enrollment Other *(specify)* _____ Date of Change Event: _____	Effective Date: _____ ☐ Permanent P/T EE *(20 hrs.)* Group ID #: _____ Group Name: _____	☐ Refuse ☐ Yes

Eligible due to the Affordable Care Act: ☐ Full-time nonpermanent ☐ Variable-Hour

ENROLLEE INFO

1. Soc. Sec. # (SSN) BIN #	2. Last Name	3. Suffix	4. First Name	5. M.I.	6. Date of Birth MM/DD/YYYY
_____ _____					

7. Sex	8. Marital Status	9. Home Phone #	10. Work Phone #	11. E-mail Address
☐ M ☐ F	☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated	( )	( )	

12. Mailing Address	13. Apt.	14. City	15. State	16. Zip Code	17. County Code	18. Annual Salary	19. Date of Hire MM/DD/YYYY

MEDICARE

20. List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

Name	Medicare #	Eligible Due To	Effective Date Part A MM/DD/YYYY	Effective Date Part B MM/DD/YYYY
		☐ Age ☐ Disability ☐ Renal Disease		
		☐ Age ☐ Disability ☐ Renal Disease		

COVERAGE

21. HEALTH PLAN *(Refuse or select one plan and one level of coverage)*

PLAN ☐ Refuse ☐ TRICARE Supplement ☐ Standard ☐ Savings

Basic Life and Basic Long Term Disability included automatically with Standard and Savings plans

COVERAGE LEVEL ☐ Employee ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Family

22. STATE DENTAL PLAN *(Select One)*

☐ Refuse ☐ Employee/Spouse ☐ Employee ☐ Employee/Child(ren) ☐ Family

23. DENTAL PLUS *(Select One)*

☐ Refuse ☐ Yes

24. DEPENDENT LIFE - Child(ren) *(Select One)*

☐ Refuse ☐ $15,000

25. DEPENDENT LIFE - Spouse *(Select One)*

☐ Refuse ☐ Coverage Level $_____ *(Must be in increments of $10,000)*

26. OPTIONAL LIFE *(Select One)*

☐ Refuse ☐ Coverage Level $_____ *(Must be in increments of $10,000)*

27. SUPPLEMENTAL LTD *(Select One)*

☐ Refuse ☐ Plan One - *90-day benefit waiting period* ☐ Plan Two - *180-day benefit waiting period*

28. VISION CARE *(Select One)*

☐ Refuse ☐ Employee ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

BENEFICIARIES

In blocks 29 and 30, if there are additional beneficiaries or dependents, list on separate sheet, signed and dated by employee.

29. Basic Life/Optional Life *(Select one or both)*	SSN#	Last Name	First Name	Relationship	Date of Birth MM/DD/YYYY	Primary or Contingent?
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent
☐ Basic Life ☐ Optional Life						☐ Primary ☐ Contingent

If beneficiary is an estate or trust, complete the following:

Estate/Trust_____ Address_____ If Trust, Date Signed_____

DEPENDENTS

30. Always list spouse. List eligible children to be covered. If they are not listed, they will not be covered. For a child age 19-24 to be eligible for Dependent Life-Child coverage, your child must be eligible according to the requirements on the reverse of this NOE.

Add (A) or Delete (D)	Dependent SSN#	Last Name	First Name	Sex M/F	Relationship	Date of Birth MM/DD/YYYY	Indicate Special Status
	Spouse						Does PEBA Insurance Benefits already cover your spouse? ☐ Yes ☐ No
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated
	Child						☐ Full-time Student ☐ Incapacitated

CERTIFICATION & AUTHORIZATION

31. CERTIFICATION: I have read this NOE and made authorizations herein and selected the coverage noted. I have provided Social Security numbers and documentation establishing my dependent(s)' eligibility for the plan(s) selected. I certify that any child enrolled in Dependent Life/Child insurance is eligible according to the requirements on the reverse of this NOE. I also understand that proof of eligibility (at the time of enrollment and at the time of the claim) will be required before any Dependent Life/Child insurance claim is paid. I understand that unless otherwise provided in the Plan, I may cancel coverage for me or my dependent(s) only during an open enrollment period. Should I refuse any coverage or fail to enroll all eligible dependents when first eligible, I and/or all eligible dependents may only enroll during an open enrollment period unless otherwise provided by the Plan. I understand and agree that all selected plans will not be effective unless and until the NOE is approved. I understand that the State reserves the right to alter benefits or premiums at any time to preserve the financial stability of the Plan. I further acknowledge that the eligibility status of any covered individual is subject to audit at any time.

AUTHORIZATION: I hereby authorize my employer to deduct from my salary premiums necessary to pay for all plans selected and verify my salary for enrollment. I authorize any healthcare provider, prescription drug dispenser and claims administrator to release any information necessary to evaluate, administer and process claims for any benefits.

DISCLAIMER: THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

Employee Signature _____ Date _____

32. I hereby attest the employee meets eligibility requirements, proper premiums are being collected, this form is complete and accurate and all required documentation is attached to process NOE form.

Benefits Administrator Signature _____ Phone _____ Date _____

NOE

INSTRUCTIONS FOR COMPLETING THE ACTIVE NOTICE OF ELECTION (NOE)

IF COMPLETING BY HAND, USE BLACK INK

You must also complete a Tobacco Certification form within 31 days of enrolling in health coverage and whenever the status of tobacco use changes for you or a dependent covered under your health insurance.

ACTION: Indicate type of action. MoneyPlus: Premiums for health, dental, vision and Optional Life up to $50,000 are deducted on a pretax basis unless refused. There is an administrative fee for the pretax deductions. Pretax MoneyPlus changes must be made during enrollment or within 31 days of a qualifying change in status event.

Blocks 1-19. ENROLLEE INFORMATION: Must be completed for all transactions, including a refusal of coverage.

Block 20. MEDICARE: List yourself and any other persons to be covered who are eligible for Part A and/or Part B of Medicare.

COVERAGE: Alterations (such as mark-throughs or white out) in this section are not allowed. To enroll, select the coverage and select the coverage level, if applicable. To refuse or cancel coverage, select "Refuse."

Block 21. HEALTH: Before making a health plan selection, refer to the plan descriptions provided by your employer.

If you refuse health coverage or fail to enroll all eligible dependents when first eligible, you can enroll yourself and/or your dependent(s) only during an open enrollment period or within 31 days of a special eligibility situation. If health coverage is refused, benefits for Basic Life and Basic Long Term Disability are forfeited.

To select a health plan, check only one block under "Health Plan" and check only one block under "Coverage Level." For dependent(s) to be covered, they must be listed in Block 30, and the appropriate level of coverage must be selected.

Block 22. DENTAL: If you refuse dental when first eligible, you can apply for coverage for yourself and your dependent(s) only during an open enrollment period during an odd-numbered year or within 31 days of a special eligibility situation. For dependents to be covered, they must be listed in Block 30, and the appropriate level of coverage must be selected.

Block 23. DENTAL PLUS: You must enroll in the State Dental Plan to enroll in Dental Plus. You must also cover the same family members under both plans.

Block 24. DEPENDENT LIFE—CHILD(REN): For child(ren) to be covered for Dependent Life Insurance, they must be listed in **Block 30.** To be eligible, they must be unmarried; must be supported by you; must not be employed on a full-time basis; and must not be in the military. In addition, for a child age 19-24 to be eligible the child must be certified by the PEBA Insurance Benefits as incapacitated at the time of enrollment or must be a full-time student at an accredited school, college or university. Children older than 24 must be certified by PEBA Insurance Benefits as incapacitated to be enrolled in Dependent Life-Child. Proof of eligibility, at the time of enrollment and at the time of the claim, will be required before any benefit will be paid.

Block 25. DEPENDENT LIFE—SPOUSE: Before making a selection, refer to the detailed instructions provided by your employer.
To select coverage, check "Coverage Level" and enter the amount of coverage for your spouse, not to exceed 50 percent of your current level of Optional Life, or $100,000. Approved medical evidence of good health is required if coverage exceeds $20,000. For your spouse to be covered, he must be listed in **Block 30.**

Block 26. OPTIONAL LIFE: Before making a selection, refer to the detailed instructions provided by your employer.

To select coverage, check "Coverage Level" and enter the amount of coverage. Coverage level may be based on your current salary (newly enrolled), a guaranteed issue and/or approved medical evidence of good health. If you do not enroll within 31 days of your date of hire, medical evidence of good health must be provided and approved to enroll or increase coverage level. However, if enrolled in the MoneyPlus Pretax Premium Feature, you must wait until the next enrollment period or within 31 days of a special eligibility situation.

Block 27. SUPPLEMENTAL LONG TERM DISABILITY: Before making a selection, refer to the detailed instructions provided by your employer.

Check only one block. If changing from "Plan Two" to "Plan One," medical evidence of good health must be provided.

Block 28. VISION CARE: Before making a selection, refer to the plan description provided by your employer.

Block 29. BENEFICIARIES: List a beneficiary for Basic Life if enrolled in health coverage and Optional Life if selected. Multiple beneficiaries may be listed. Beneficiaries must be listed individually by a name or organization. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named survivors. Contingent beneficiaries have no rights unless all primary beneficiaries have died.

Block 30. DEPENDENTS: Legal documentation is required for all dependents. If you select a level of coverage that includes a spouse and/or dependent child(ren), they must be listed to be covered. A spouse can only be covered as a dependent if he is not an employee or retiree of an employer that participates in the State of South Carolina Insurance Benefits Program. If your spouse is an employee or retiree of a PEBA Insurance Benefits-covered employer, check "Yes."

A child younger than 26 is eligible for health, dental and vision coverage. Misstatements on the NOE may result in termination of the dependent's coverage and recoupment of benefits paid on behalf of the ineligible dependent.

CERTIFICATION AND AUTHORIZATION: Form must be signed and dated by employee within 31 days of hire or the qualifying event.

The benefits administrator must sign and date form and attach copies of all supporting documentation before submitting it to the **PEBA Insurance Benefits at P.O. Box 11661 Columbia, SC 29211-1661.**

Retirement Plan Enrollment 1 of 2

Form 1100
Revised 9/23/2014
Page 1

RETIREMENT PLAN ENROLLMENT

S.C. Public Employee Benefit Authority
Retirement Benefits
Attention: Enrollment
Box 11960, Columbia, SC 29211-1960

Print or type in black ink
Please read the instructions on Page 2 before completing this form.

ACTION REQUESTED (Check One):

- ☐ NEW ENROLLEE (First-time membership)
- ☐ OPEN ENROLLMENT (Irrevocable election from State ORP)
- ☐ CHANGE OF EMPLOYER (Transfer)/DUAL EMPLOYMENT
- ☐ CHANGE OF INFORMATION
  - ☐ Name (Prior Name): _____
    (ATTACH LEGAL DOCUMENT INDICATING NAME CHANGE
  - ☐ Address
  - ☐ SSN (Old Number): _____
  - ☐ Date of Birth

SECTION I: EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

1. Last Name & Suffix	2. First/ Middle Name	3. Social Security Number (attach copy of Social Security card only if changing SSN)	
4. Address	5. City	6. State	7. ZIP+4

8. Gender M - Male F - Female	9. Date of Birth	10. Telephone Number	11. Email Address

12. Have you ever been a member of PEBA's retirement systems? ☐No ☐Yes

13. If item 12 is "Yes", indicate the name(s) of your former employer: _____
Did you withdraw your contributions? ☐No ☐Yes

14. Do you currently have a pending refund request? ☐No ☐Yes

15. Are you now receiving or have you applied to receive a monthly benefit from any of PEBA's retirement systems? ☐No ☐Yes ☐Application in Process

16. Retirement Plan Election (CHOOSE ONE)
☐ SCRS ☐ PORS (See Instructions) ☐ State ORP (If State ORP, please complete item 17.)
☐ JSRS (Judge, Solicitor, Circuit Public Defender, or Administrative Law Court)

17. Select State ORP Vendor
☐ MassMutual ☐ MetLife
☐ TIAA-CREF ☐ VALIC

18. An employee hired by an eligible employer (school district, higher education, technical college, state department, agency, bureau, commission, and institution) covered under the South Carolina Retirement System (SCRS), or individuals first elected to the S.C. General Assembly in and after November 2012, may elect to participate in either the traditional defined benefit plan, SCRS, or the optional defined contribution plan, State Optional Retirement Program (State ORP). The election to participate in State ORP must be made within 30 calendar days after entry into service (date of hire).

If I do not make an election within the required time, I will be considered to have elected membership in SCRS. Participants in the State ORP assume all investment risk. The election to participate in State ORP is irrevocable, except a State ORP participant may make a one-time irrevocable election to join SCRS during any open enrollment period after the first annual anniversary, but before the fifth annual anniversary of the initial enrollment in State ORP.

I understand that, unless a designated beneficiary is on file, my estate will be designated as my beneficiary until PEBA receives from me a properly executed beneficiary form.

My signature below indicates that my employer has explained the retirement plan options available to me and has provided me with access to information necessary to make an informed choice. My signature on this document confirms my retirement plan election as indicated in block 16 above.

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS AND DOES NOT CREATE A CONTRACT BETWEEN THE MEMBER AND THE PUBLIC EMPLOYEE BENEFIT AUTHORITY. THE PUBLIC EMPLOYEE BENEFIT AUTHORITY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT.

Employee's Signature _____ Date _____ Witness _____
(Required only when signed by mark)

SECTION II: EMPLOYER INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

19. Employer Code	20. Employer Name	21. Please indicate if you are the employee's primary or secondary employer. ☐ Primary Employer ☐ Secondary Employer

22. Original Date of Hire with Employer listed in Items 19-20	23. Date of Membership	24. Employee's Position Title	25. Employee's Annual Salary

26. I hereby certify that the employee listed in Section I of this form is eligible for the retirement plan selected.

Employer Signature _____ Date _____

Work Telephone _____

For more information, please contact Customer Services at 803-737-6800, 800-868-9002 (within S.C. only), or www.retirement.sc.gov

Retirement Plan Enrollment

INSTRUCTIONS
(PLEASE READ BEFORE COMPLETING AND SIGNING THIS FORM)

Complete this form: to enroll a new member; to change a member's employer, name, address, date of birth, or Social Security number; for employees who have had a break-in-service (those who return from a leave-without-pay status of more than 13 months); or when changing from one retirement system to another, regardless of prior membership.

ACTION REQUESTED - (CHECK APPROPRIATE BOX) (THE EMPLOYER MAKES THESE SELECTIONS.)

NEW ENROLLEE: Enrolling in the Retirement Systems for the first time.
OPEN ENROLLMENT: Irrevocable election from State ORP - Employee previously participated in State ORP, but is now irrevocably electing membership in SCRS during open enrollment period, after the first annual anniversary but before the fifth annual anniversary of the person's initial enrollment in State ORP.
CHANGE OF EMPLOYER/Dual employment: A member of the Retirement Systems transferring or accepting a position with another employer or a new hire with funds on deposit in the Retirement Systems.
CHANGE OF INFORMATION: Changing any of the listed information and to request that the Retirement Systems update its records on the employee accordingly.

Name (Prior Name): Attach a copy of the marriage license or other legal document authorizing the name change. Indicate the employee's **old name** in the space provided and list his **new name** in items 1-3 in Section I.
Address: List employee's new address (items 4-7 in Section I).
SSN (Old Number): Change/correct an employee's Social Security number by listing **old Social Security number** in the space provided and completing items 1-3 in Section I. (The employee's **new Social Security number** should be listed in item 3 in Section I). Include a copy of Social Security card with correct SSN.
Date of Birth: Change an employee's date of birth by completing items 1-9 in Section I.

SECTION I - ITEMS 1-18 INSTRUCTIONS (THE EMPLOYEE COMPLETES AND SIGNS THIS SECTION.)

Items 1 - 11: Complete items 1-11 by providing the requested information.
Item 12: Indicate if you have prior membership in any of the five retirement plans (SCRS, State ORP, PORS, GARS, or JSRS).
Item 13: If item 12 is "yes," provide the name(s) of the employer(s) for whom you worked and through which you contributed to one of PEBA's retirement systems or State ORP, and indicate whether or not you received a refund of your contributions.
Item 14: Indicate whether or not you currently have a pending refund request.
Item 15: Indicate whether or not you are receiving or have applied to receive a monthly benefit from the PEBA.
Item 16: Select the retirement plan of your choice (check appropriate box). You must be eligible for membership in the retirement plan you select. To be eligible for PORS membership, an employee must be required by the terms of his employment, by election or appointment, to preserve public order, protect life and property, and detect crimes in the state; to prevent and control property destruction by fire; be a coroner in a full-time permanent position; or be a peace officer employed by the Department of Corrections, the Department of Juvenile Justice, or the Department of Mental Health. Probate judges and coroners may elect membership in PORS. Magistrates are required to participate in PORS for service as a magistrate. PORS members, other than magistrates and probate judges, must also earn at least $2,000 per year and devote at least 1,600 hours per year to this work, unless exempted by statute. By signing this form as an employer, you are certifying that the employee meets these eligibility requirements. GARS is closed to members of the General Assembly who are first elected to serve in and after November 2012; however, these members may elect to join SCRS, State ORP, or non-membership.
Item 17: If you elected State ORP, you must check the appropriate box to indicate your vendor selection.
Item 18: Please sign and date the form after you have completed items 1-17.
Your employer will complete the remainder of the form (Section II).

SECTION II - ITEMS 19-25 INSTRUCTIONS (THE EMPLOYER COMPLETES AND SIGNS THIS SECTION.)

Items 19-20: Indicate the five-digit employer code assigned to your organization by the Retirement Systems and list the name of your organization.
Item 21: Indicate if this will be the employee's primary or secondary employer.
Item 22: List the date the employee was originally hired by the current employer.
Item 23: List the date the employee will begin making contributions to his chosen retirement plan through the current employer. If an employee is electing irrevocable membership in SCRS during the State ORP open enrollment period, the effective date must be April 1 of the current year.
Item 24: Indicate the employee's position title.
Item 25: List the employee's annual salary. If the employee is part-time, the salary may be listed as an hourly wage.
Item 26: Please sign and date the form, and provide your work telephone number so that the Enrollment staff may contact you if necessary.

admin
THE SOUTH CAROLINA DEPARTMENT of ADMINISTRATION

Background Check Authorization

As a condition of my candidacy for employment or in connection with a student, intern, volunteer, or affiliate capacity with the SC Department of Administration (Department), I understand that the Department will conduct a background check screening about me for employment purposes or for student/volunteer/employment placement purposes. The information will not be used for other purposes.

By signing this Authorization, I hereby authorize the Department to obtain consumer credit reports and/or investigative consumer reports about me. I understand and acknowledge that this Authorization allows the Department and General Information System (GIS), or any other company authorized by the Department, to contact any and all corporations, companies, entities, or organizations, including, but not limited to, my current and former employers, consumer reporting agencies, credit agencies, education institutions, law enforcement agencies, city, state, county, and federal courts and agencies, and military services, and I authorize any and all persons and entities contacted to release information about my background, including, but not limited to, information about my employment, address history, professional licenses and credentials, lawsuit history, social security number validation, education, consumer credit history, driving record, criminal record, general public records' history and any other public or private information sources. Some government agencies and other information sources require date of birth, social security number, driver's license number and state when checking for records.

I understand that before taking any adverse action based in whole or in part on the report, the Department's Office of Human Resources shall provide me a copy of the report and a description in writing of my rights under the Fair Credit Reporting Act (FCRA). The Consumer Financial Protection Bureau's "Summary of Your Rights under the Fair Credit Reporting Act" is available in English and Spanish. You may also contact the Department's Office of Human Resources to request a copy of the report.

CALIFORNIA, MINNESOTA AND OKLAHOMA APPLICANTS/EMPLOYEES ONLY: Check here _____ to receive a free copy of any requested Consumer Report, Investigative Consumer Report or Credit Report on you.

NEW YORK: You have the right, upon written request, to be informed of whether or not a consumer report was requested. If a consumer report is requested, you will be provided with the name and address of the consumer reporting agency furnishing the report.

To be completed by candidate. Please print clearly. Any information that is not legible will cause delay.

Last Name:	First Name:	Middle Name:
Social Security Number:	Former/Other Names Used:	

Sex:	Race:	Date of Birth: (mm/dd/yyyy)	Driver's License Number and State:

Name as it Appears on License:	Phone Number:
Email Address:	

Please provide all addresses where you have lived for the past seven years. Use the back of this form if you need more room.

	Full Street Address	Apt.#	City/State	Zip Code	Month/Year
Current:					
Former:					
Former:					

	Check here if additional addresses are on the back or attached.	May we contact your current employer?	Yes	No

I represent to the best of my knowledge that all information provided above is accurate, true and correct, and that I fully understand the terms of this Authorization. I have read, and comprehend this form and hereby authorize, any person, company or other entity contacted by General Information Systems (GIS) or the Department of Administration, to provide the information stated above. If I am selected, this Authorization shall remain in effect for the length of my employment or participation. I agree that a fax, photocopy or electronic copy of this Authorization with my signature will be accepted with the same authority as the original. I am also aware that a consumer report may be obtained for employment or placement purposes.

Signature: Print Name: Date:

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

PERSONNEL DATA

RACE
W White
B Black/African American
H Hispanic/Latino
O Asian
A American Indian/Alaska Native
N Native Hawaiian/Other Pacific Islander
T Two or More Races

MARITAL STATUS
M Married
S Single
D Divorced
W Widow **or** Widower
A Separated

EDUCATION
12 High School Graduate/GED
13 Completed one year of college
14 Completed two years of college
15 Completed three years of college
16 Associate's degree
17 Bachelor's degree
18 Master's degree
19 Doctorate
20 Juris Doctorate
21 Medical Doctorate

COUNTY CODES

01 Abbeville	**16** Darlington	**31** Lee
02 Aiken	**17** Dillon	**32** Lexington
03 Allendale	**18** Dorchester	**33** McCormick
04 Anderson	**19** Edgefield	**34** Marion
05 Bamberg	**20** Fairfield	**35** Marlboro
06 Barnwell	**21** Florence	**36** Newberry
07 Beaufort	**22** Georgetown	**37** Oconee
08 Berkeley	**23** Greenville	**38** Orangeburg
09 Calhoun	**24** Greenwood	**39** Pickens
10 Charleston	**25** Hampton	**40** Richland
11 Cherokee	**26** Horry	**41** Saluda
12 Chester	**27** Jasper	**42** Spartanburg
13 Chesterfield	**28** Kershaw	**43** Sumter
14 Clarendon	**29** Lancaster	**44** Union
15 Colleton	**30** Laurens	**45** Williamsburg
		46 York

EMPLOYEE INFORMATION (Please use Codes listed above where applicable)

EMPLOYEE'S NAME

HOME ADDRESS | CITY | STATE | ZIP CODE | COUNTY CODE

RACE | SEX | MARITAL STATUS | EDUCATION

DATE OF BIRTH | DRIVERS LICENSE NUMBER | CLASS | STATE | EXPIRATION DATE | SOCIAL SECURITY NUMBER

HOME PHONE NUMBER

PRIOR STATE SERVICE (AGENCY & DATES: FROM/TO)

Have you ever been a TERI employee or are you a retired member of the Public Employee Benefit Authority or PEBA (formerly the South Carolina Retirement Systems)?

EMERGENCY CONTACT INFORMATION (Employee is responsible for updating this information as changes occur via MySCEmployee.)

1. | RELATIONSHIP | HOME PHONE:_____ WORK PHONE:_____

ADDRESS

2. | RELATIONSHIP | HOME PHONE: _____ WORK PHONE:_____

ADDRESS