THE UNIVERSITY OF
SCRANTON
A JESUIT UNIVERSITY

Office of Human Resources

Change in Marital Status
Add or Remove a Spouse/Dependent Packet

Benefit forms need to be completed when a benefit eligible staff or faculty member changes address, marital status, and/or benefit plan enrollment. These forms need to be completed and returned to the Human Resources office within 30 days of the qualifying event and/or status change.

- ✓ **Qualifying Events:** A change in your situation — like getting married, having a baby, or losing health coverage — that can allow benefit plan changes outside the yearly Open Enrollment Period
- ✓ **Verifying dependents:** When enrolling a spouse or child (or changing a spouse or child's enrollment) in University Benefits, documentation demonstrating the current spousal or child relationship may be required

You only need to complete the forms that pertain to you.

Forms to be returned for a marital status change, including adding or removing a spouse or dependent:

- Office of Human Resources Data Change Form
- W-4 (only if you wish to change your federal withholding)
- Residency Certification
- Highmark Enrollment
  - Only complete section 1, *Employee Information*; complete section 2 *Dependent Information to* add/remove a spouse or dependent
- United Concordia Dental Enrollment
  - Only complete section A & C; Complete section D *Dependent* Information to add/remove a spouse or dependent
- Retirement Vendor Information Change Form
  - Only complete the form for the vendor you have an account with
- Medical/Dental Enrollment Option Form
- TIAA or Transamerica Beneficiary Designation Form
  - Only complete the form for the vendor you have an account with and only if you are choosing to update the beneficiary
- Cigna Life Insurance Beneficiary Designation Form *(not in the packet, must be opened separately)*
  - Only complete the form for the vendor you have an account with and only if you are choosing to update the beneficiary

All forms are available in the Office of Human Resources, St Thomas Hall room 100

SCRANTON, PENNSYLVANIA 18510-4668
(570) 941-7767 FAX: (570) 941-4636

Office of Human Resources
Data Change Form

Please print all information in ink.

Name: _____ R# _____

Effective Date of Change: _____

Check the appropriate box(es) to indicate a change to my personal information as indicated below:

☐ Name: _____
(Please provide supporting documentation i.e. marriage certificate, divorce decree, etc.)

☐ Physical Address: _____ ☐ If different, provide Mailing:

_____ _____

_____ _____

_____ _____

☐ Telephone Number: _____ ☐ Home ☐ Cell

☐ Marital Status: *Please provide supporting documentation i.e. marriage certificate, divorce decree, etc.*

☐ Single ☐ Married ☐ Widowed ☐ Divorced

☐ Add ☐ Remove the following spouse/dependent(s):
Please provide supporting documentation i.e. birth certificate, marriage license, divorce decree, etc

Name	Relationship	Gender	Date of Birth	Social Security #
	☐ Spouse ☐ Dependent	☐ Male ☐ Female		
	☐ Spouse ☐ Dependent	☐ Male ☑ Female		
	☐ Spouse ☐ Dependent	☐ Male ☐ Female		

Change emergency contact person: (if applicable)

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone Number)

_____
(Signature)

_____
(Date)

Highmark _____
UCCI _____
COBRA _____

Received in HR _____
Date Completed _____

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2023

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		**Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

(c) ☐ **Single** or **Married filing separately**
☐ **Married filing jointly** or **Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Reserved for future use.

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

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

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

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

Step 3: Claim Dependent and Other Credits

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

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

Multiply the number of other dependents by $500 $ _____

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

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

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

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

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

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

Specific Instructions

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

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

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

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

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

Step 4 (optional).

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

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

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

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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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.

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 2023 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $20,800 if you're head of household
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $13,850 if you're single or married filing separately

. . . . . **2** $

3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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 Part II of Schedule 1 (Form 1040)). 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** $

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 with no other entries on the form; 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 territories 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.

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

CLGS-32-6 (6-13)

RESIDENCY CERTIFICATION FORM
Local Earned Income Tax Withholding

TO EMPLOYERS/TAXPAYERS:

This form is to be used by employers and/or taxpayers to report essential information for the collection and distribution of Local Earned Income Taxes to the local EIT collector. This form must be utilized by employers when a new employee is hired or when a current employee notifies employer of a name and/or address change. Use the Address Search Application at www.newPA.com/Act32 to determine PSD codes, EIT rates and tax collector contact information.

EMPLOYEE INFORMATION – RESIDENCE LOCATION

NAME (Last Name, First Name, Middle Initial)			SOCIAL SECURITY NUMBER
STREET ADDRESS **(No PO Box, RD or RR)**			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	DAYTIME PHONE NUMBER
MUNICIPALITY (City, Borough or Township)			
COUNTY	RESIDENT PSD CODE		TOTAL RESIDENT EIT RATE

EMPLOYER INFORMATION – EMPLOYMENT LOCATION

EMPLOYER BUSINESS NAME (Use Federal ID Name)			EMPLOYER FEIN
University of Scranton			240795495
STREET ADDRESS WHERE ABOVE EMPLOYEE REPORTS TO WORK **(No PO Box, RD or RR)**			
800 Linden St			
ADDRESS LINE 2			
CITY	STATE	ZIP CODE	PHONE NUMBER
Scranton	PA	18510	570-941-7767
MUNICIPALITY (City, Borough or Township)			
Scranton			
COUNTY	WORK LOCATION PSD CODE		WORK LOCATION NON-RESIDENT EIT RATE
Lackawanna	350901		

CERTIFICATION

Under penalties of perjury, I (we) declare that I (we) have examined this information, including all accompanying schedules and statements and to the best of my (our) belief, they are true, correct and complete.

SIGNATURE OF EMPLOYEE	DATE (MM/DD/YYYY)
PHONE NUMBER	EMAIL ADDRESS

For information on obtaining the appropriate MUNICIPALITY (City, Borough, Township), PSD CODES and EIT (Earned Income Tax) RATES, please refer to the Pennsylvania Department of Community & Economic Development website:

www.newPA.com/Act32

ENROLLMENT/WAIVER FORM

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

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

☑ **WAIVING** (Complete sections I and III)

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

Effective Date	Employer/Group Name	Group Number	Payroll Location

First Name	MI	Last Name	Social Security Number *(If no SS#, write N/A)*

Address

City	State	Zip	County	Home/Cell Phone

Marital Status *(Please check one)*:
☐ Single/Widowed ☐ Married ☐ Divorced

Enrollment Status
☐ Active Employee ☐ COBRA Continuant Start Date / /
☐ Rehired Employee ☐ HIPAA Life Event
(Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)

Full-Time Hire (or Rehire) Date *(Month/Day/Year)*	Hours Worked Per Week	Job Title
/ /		

Gender	Date of Birth *(Month/Day/Year)*	Age	Product Selection(s)
☐ Male ☐ Female	/ /		☐ Medical Product Name: _____ ☐ Vision ☐ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		☐ Yes ☐ No

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

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			☐ Spouse ☐ Domestic Partner †

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

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

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		☐ Yes ☐ No

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

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

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ☐ Child ☐ Step-child ☐ Adopted* ☐ Other*

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

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

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		☐ Yes ☐ No

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

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

DEPENDENT CHILD

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

DEPENDENT CHILD

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

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

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

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

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

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

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ☐ Insured under spouse. Please provide spouse's employer and insurance carrier names:

_____

- ☐ Other:

_____

VISION

I HEREBY DECLINE VISION COVERAGE:

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

_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

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

_____

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

_____ _____

Employee/Contract Holder Signature | Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			☐ Active ☐ Retired ☐ Date of Retirement: / /

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

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

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

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

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

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

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

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

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

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

Fax (800) 290-3301

https://www.enrollmentandbilling@highmark.com

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

To find more information about our benefits and operating procedures, such as accessing the drug formulary or using network providers, please go to DiscoverHighmark.com/QualityAssurance; or for a paper copy, call 1-855-873-4106.

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefits determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your Member ID card to request these free services (TTY/TDD users may call 711).

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UNITED CONCORDIA® Dental Enrollment Form

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please select the applicable "Type of Activity" in Section A and provide the identification number and employee name in Section C (also complete Section D for dependent changes).

Fill in circles completely: ● Correct ⊗ Incorrect

For best results, print in capital letters and avoid contact with edge of box.

Example: A B C

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

- ○ **FFS—Indemnity, Active PPO, Passive PPO** (Please specify)
  - ○ Concordia Access
  - ○ Concordia Choice
  - ○ Concordia Flex
  - ○ Concordia Preferred
  - ○ Concordia Select
  - ○ Other_____
- ○ **DHMO** (Please specify)
  - ○ Concordia Plus
  - ○ Other_____

Provider Number (DHMO only)

2. TYPE OF ACTIVITY

- ○ **New Enrollment**
- ○ **Cancel Coverage**
  - ○ Cancel All Coverage (Employee & All Dependents)
  - ○ Cancel Dependent(s) Only (List dependents to be cancelled in Section D)
  - ○ Cancel Spouse Only (List spouse to be cancelled in Section D)
- ○ **Change (Include Group Number in Section B)**
  - ○ Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - ○ Change Address
  - ○ Reinstate Coverage
  - ○ Change Group Number
  - ○ Change Provider
  - ○ Change Name
  - ○ To COBRA Group
  - ○ Other_____

Effective Date (mm/dd/yyyy) / /

SECTION B: EMPLOYER USE ONLY

Employer Name

Group Number (9 digits)

UCCI Payroll Location

SECTION C: EMPLOYEE INFORMATION—Please print clearly to expedite your request.

Identification Number (Social Security Number) **Date of Birth** (mm/dd/yyyy) / / **Sex** **Original Employment Date** (mm/dd/yyyy) / /

First Name **M.I.** **Last Name**

Home Address

City **State** **ZIP Code**

SECTION D: DEPENDENT INFORMATION—Please list the added/cancelled dependents in this section. For more than six dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

Spouse/Domestic Partner

#1 **Identification Number** (Social Security Number) **Date of Birth** (mm/dd/yyyy) / / **Sex** **Provider Number** (DHMO only)

First Name **M.I.** **Last Name**

Dependent

#2 **Identification Number** (Social Security Number) **Date of Birth** (mm/dd/yyyy) / / **Sex** **Provider Number** (DHMO only)

First Name **M.I.** **Last Name**

#3

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#4

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#5

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#6

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Sex** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

SECTION E: OTHER DENTAL COVERAGE—Do you or your dependent(s) have other Group Dental Coverage? Yes ◯ No ◯
If your answer is yes, please complete the following information.

Policyholder Name (First, M.I., Last)	**Insurance Company**
Policy/Identification Number	**Effective Date** (mm/dd/yyyy)

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Employee Signature | **Phone Number** | **Email Address** | **Date**

Employer Signature | **Phone Number** | **Date**

Program Availability

- Products are not available in any state where prohibited by law or where United Concordia does not have regulatory approval.
- Domestic partner coverage is not permitted in Idaho.

State Mandated Provisions

CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

AZ, GA, KY, NE & NH: All statements made by a Policyholder or by any Insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.

KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

OR: Contestability is limited to two years as stated in the Group Policy.

TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

UT: Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the Rules of (the American Arbitration Association or other recognized arbitrator), a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

United Concordia operates as a wholly owned subsidiary under the name listed below in the following states:

- United Concordia Dental Corporation of Alabama—AL
- United Concordia Dental Plans, Inc.—DC, MD, NJ
- United Concordia Dental Plans of California, Inc.—CA
- United Concordia Dental Plans of Florida, Inc.—FL
- United Concordia Dental Plans of Kentucky, Inc.—KY
- United Concordia Dental Plans of the Midwest, Inc.—MI, MO, OH
- United Concordia Dental Plans of Pennsylvania, Inc.—PA
- United Concordia Dental Plans of Texas, Inc.—TX
- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY

MEDICAL/DENTAL ENROLLMENT OPTION FORM

I. Premium Conversion Plan

125 participant:

a. ☐ I wish to participate in the Premium Conversion Plan and make contributions toward the cost of medical and dental insurance premiums with pre-tax dollars. I understand that my compensation will be reduced while this election is in effect, and the amount of the reduction will be the amount of the cost of the insurance premiums.

125 non-participant:

b. ☐ I decline participation in the Premium Conversion Plan. I understand that payment of any medical and dental insurance premiums will be with after-tax dollars.

II. Opt-Out Plan

☐ I wish to waive medical and dental insurance coverage which the University provides for employees and spouses and/or dependents and hereby certify that medical insurance is provided elsewhere. I understand that except for a life event as defined by the IRS, I will only be allowed to opt back into coverage during the annual open enrollment period.

Name:_____

Date:_____

Signature:_____

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

QUESTIONS?
For account information or any questions:

Call **800 842-2252**
Monday – Friday
8 a.m. – 10 p.m. (ET)

Saturday
9 a.m. – 6 p.m. (ET)

Or visit us online at **tiaa-cref.org** 24 hours a day. Have your user ID and password ready.

IMPORTANT INFORMATION

Use this form to update existing or to designate new beneficiary(ies) on your TIAA-CREF pension and/or IRA accounts. For changes to other product or account types, please visit us at **tiaa-cref.org** or call us at **800 842-2252**.

Did you know that incomplete information can make it difficult for us to find your beneficiaries?
To help ensure that your beneficiaries receive their survivor benefits, it's important that we have complete information on file to locate them at all times. This includes each beneficiary's name, address, telephone number, date of birth, Social Security Number or Taxpayer Identification Number and relationship to you and the portion of the benefits to which they are entitled. If you haven't already done so, please update your beneficiary designation with all of this information as soon as possible. And, we also recommend that you review and update your beneficiary information periodically to make sure it continues to be accurate.

To update or change your beneficiary designation, please visit us online at **www.tiaa-cref.org/profile** or complete this Designation of Beneficiary form and mail back to us. To obtain a form, visit our website at **www.tiaa-cref.org/beneficiary**, or call us at **800 842-2252**.

Selecting a Beneficiary
A beneficiary can be an individual, an institution, an organization, a testamentary trust, or your estate. (Naming an estate may limit options available to your heirs. Please consult with an attorney prior to naming your estate or trust.) Beneficiaries can also be the children of the beneficiaries that you designate on this form. You can choose primary and contingent beneficiaries. Your primary beneficiary(ies) receives benefits at the time of your death. If a class includes more than one person, the benefits are paid proportionately among the living beneficiaries of the class unless you specify otherwise. If there are no living primary beneficiaries at the time of your death, the benefits become payable to your contingent beneficiaries. If none of the beneficiaries are living at the time of your death, the benefits will default to the plan or product provisions. The order of payment and division of benefits is provided for in the Additional Provisions section.

Spousal Rights to Annuity Death Benefits
If you live in a community or marital property state and have designated someone other than your spouse as more than 50% primary beneficiary, you need to consult your tax advisor regarding the effect that may have on your beneficiary designation. Community and marital property states include, but are not limited to: AZ, CA, ID, LA, NV, NM, TX, WA and WI.

Federal pension law (ERISA) and certain Plan and State provisions mandate:

If you are married at the time of your death, your spouse is entitled to receive, as primary beneficiary, at least 50%, could be up to 100%, of your qualified preretirement survivor annuity death benefits under a retirement or tax-deferred annuity plan covered by any of the following: ERISA or your plan's spousal policy. If you name someone other than your spouse as primary beneficiary of those qualified preretirement survivor annuity death benefits, then we will be obligated to pay your spouse **regardless of your beneficiary designation in effect at the time of your death.** The remainder will be payable in proportion of the amounts allocated to the other beneficiary(ies) listed as primary.

CONTINUED ON NEXT PAGE

Please contact your human resources administrator for any special employer rules.

IMPORTANT INFORMATION (CONTINUED)

How to waive a preretirement survivor death benefit?

Please consult with your Plan Representative for more information.

If you are married and want more than 50% of your benefits (or the plan determined amount, if greater) to go to someone other than your spouse, your spouse must authorize the designation by completing the Spousal Waiver form. A Notary Public or Plan Representative must witness your spouse signing and dating the spousal waiver. Under federal law, if you are under 35, your spouse cannot complete a Spousal Waiver unless your plan provides otherwise. Even if your plan does allow your spouse to complete a Spousal Waiver, your spouse must complete another Spousal Waiver once you attain age 35.

If the spousal waiver section is not completed and signed at the time you make your designation, we will continue to update your designation but at the time of your death, we will advise your spouse of his/her legal right to their portion of your contract at which time he/she can waive their rights or claim their inheritance.

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

Print in upper case using black or dark blue ink and provide all information requested.

To help avoid incorrect interpretation or delays, please be sure that all handwritten information is legible.

1. PROVIDE YOUR INFORMATION

First Name

Middle Initial

Last Name

Suffix

Social Security Number/
Taxpayer Identification Number

Date of Birth (mm/dd/yyyy)

Address

City

State

Zip Code

Contact Telephone Number

Extension

Email Address

Please note: TIAA-CREF contractual rules state that we will recordkeep beneficiary(ies) at an individual-contract level, not a plan-based level.

2. DESIGNATION TYPE (CHOOSE ONE)

Please note whether this is a new designation request or an update to an existing designation.

☐ **New designation**

NOTE: If you select this option, it will completely replace any prior designations for each of your accounts named in Section 3.

☐ **Update to an existing beneficiary(ies)**

(Ex: Name change, Address change, update SSN, etc.)

Check the first box if you want the same beneficiary designation(s) for all your applicable TIAA-CREF annuity contracts. Check the second box only if you want the beneficiary designation applied to specific contracts.

NOTE: Designations can only be at the contract level. Plan-based designations are not acceptable.

3. APPLICABLE CONTRACTS

This beneficiary designation applies to:

☐ ALL my active TIAA-CREF pension, annuity and IRA contracts

OR

☐ ONLY my TIAA-CREF pension, annuity or IRA contract set(s) indicated below:

TIAA Number	CREF Number
TIAA Number	CREF Number
TIAA Number	CREF Number

NOTE: If you wish to make changes to other products you hold at TIAA-CREF, please visit us at **tiaa-cref.org** or call us at **800 842-2252**.

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

A beneficiary can be an individual, an institution, an organization, a trust, a testamentary trust,* or your estate. Your primary beneficiaries receive benefits after your death. If no primary beneficiary is living, the benefits become payable to your contingent beneficiaries. If none of the beneficiaries are living at the time of your death, the benefits go to your estate.

*TIAA cannot accept a 'Will' as a designation. Testamentary trusts are acceptable IF we are provided the date the Will, under that Testamentary Trust, was issued.

If your percentage does not equal 100% or is not provided, we will prorate the unspecified percentage equally.

**If you check 'per stirpes' and the named beneficiary predeceases you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary their portion will be paid proportionately to the remaining beneficiaries in that class. In the event there are no other beneficiaries, we will pay your Estate.

See Provisions at end of this form.

4. CHOOSING YOUR PRIMARY BENEFICIARY

Tell us who should receive your account balance after your death.

☐ To the person I am legally married to at the time of my death.

NOTE: If you choose the person you are legally married to as defined under federal law at the time of your death, we will pay 100% to your spouse. Please do not complete any information in the primary beneficiary section if you make this election. We will obtain all the pertinent information about your spouse at the time of your death. If you choose this option and you are not married at the time of your death, we will pay the contingent beneficiaries you designate on this form.

OR

1. PRIMARY BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes**

2. PRIMARY BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes**

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

If you have more than one primary beneficiary, benefits will be divided equally among the living beneficiaries unless you specify the percentage. The percentages for all of the primary beneficiaries must total 100%.

TIAA cannot accept a 'Will' as a designation. Testamentary trusts are acceptable IF we are provided the date the Will, under that Testamentary Trust, was issued.

*If you check 'per stirpes' and the named beneficiary predeceases you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary their portion will be paid proportionately to the remaining beneficiaries in that class. In the event there are no other beneficiaries, we will pay your Estate.

4. CHOOSING YOUR PRIMARY BENEFICIARY (CONTINUED)

3. PRIMARY BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes*

4. PRIMARY BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes*

☐ **Check this box and attach a signed letter, to list additional primary and/or contingent beneficiaries, a trust, or to provide additional instructions. Please include your contract numbers.**

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

If you have more than one contingent beneficiary, benefits will be divided equally among the living beneficiaries unless you specify the percentage. The percentages for all of the contingent beneficiaries must total 100%.

TIAA cannot accept a 'Will' as a designation. Testamentary trusts are acceptable IF we are provided the date the Will, under that Testamentary Trust, was issued.

*If you check 'per stirpes' and the named beneficiary predeceases you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary their portion will be paid proportionately to the remaining beneficiaries in that class. In the event there are no other beneficiaries, we will pay your Estate.

5. CHOOSE YOUR CONTINGENT BENEFICIARIES

Tell us who should receive your account balance after your death.

1. CONTINGENT BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes*

2. CONTINGENT BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes*

CONTINUED ON NEXT PAGE

TIAA CREF
Financial Services

BENEFICIARY DESIGNATION FORM

If you have more than one contingent beneficiary, benefits will be divided equally among the living beneficiaries unless you specify the percentage. The percentages for all of the contingent beneficiaries must total 100%.

TIAA cannot accept a 'Will' as a designation. Testamentary trusts are acceptable IF we are provided the date the Will, under that Testamentary Trust, was issued.

*If you check 'per stirpes' and the named beneficiary predeceases you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary their portion will be paid proportionately to the remaining beneficiaries in that class. In the event there are no other beneficiaries, we will pay your Estate.

5. CHOOSE YOUR CONTINGENT BENEFICIARIES (CONTINUED)

3. CONTINGENT BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes*

4. CONTINGENT BENEFICIARY

First Name | Middle Initial

Last Name | Percentage

Address

City | State | Zip Code

Contact Telephone Number — — | Country | Gender ☐ F ☐ M

Social Security Number/ Taxpayer Identification Number | Date of Birth/Date of Trust/ Issue Date of Will (mm/dd/yyyy) / / | Relationship

☐ Per stirpes*

Please provide your signature and the date.

6. YOUR SIGNATURE

I, the undersigned, agree that:

- All prior beneficiary designations previously requested and any benefits due by reason of my death will be payable to the beneficiary(ies) named on this form, if I elected option 1 in Section 2.
- I understand that this form is subject to all of the terms and conditions of the pension, annuity and IRA contracts as described in Section 3.
- I reserve the right to make further changes to my beneficiary designations.
- If you named an irrevocable beneficiary, your annuity partner will be unable to change the designation at any time.
- I understand that if I elect to have this designation apply to all of my referenced accounts, it will apply ONLY to those active as of the date this form is accepted by TIAA-CREF.
- I understand that if any or all of my accumulation for which this designation applies is subject to Spousal Consent under plan or ERISA rules, my spouse must complete a spousal waiver form.
- I understand that if I elect 'per stirpes,' that I agree with TIAA's interpretation of how the benefits at my death will be paid as outlined in this form.
- I understand and agree to the changes and updates I made on this form.

Your Signature

Today's Date (mm/dd/yyyy)

/ / 20

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BENEFICIARY DESIGNATION FORM

The Employee Retirement Income Security Act of 1974 (ERISA) provides certain rights to the spouse of a participant in a retirement plan subject to the law. Some Non-ERISA plans may also require that we pay from 50% to 100% to a surviving spouse at death.

NOTE: Due to Plan Provisions or Employee Retirement Income Security Act (ERISA) regulations we need to verify if there is a surviving spouse. This verification will be completed prior to benefits being paid/ settled to any beneficiary.

7. ADDITIONAL REQUIREMENTS BASED ON MARITAL STATUS

7A. IF YOU ARE SINGLE, COMPLETE THIS SECTION

Check the box if you are not married.

☐ I am not married.

7B. IF YOU ARE MARRIED

If you are married and have not designated your spouse as a primary beneficiary for at least 50% of the benefit, or the percentage required by ERISA or your plan, your spouse must complete this section in front of a Notary Public or your current employer's plan representative.

In order to ensure that your spouse has seen your intentions and can attest that they fully agree to waive their rights, your spouse's signature must be the **same or a later** date than you signed in Section 6.

Consent by Spouse (Must Be Completed by Your Spouse and Witnessed)
With this consent, I voluntarily and irrevocably give up my right to a death benefit that I may be entitled to under spousal consent/law. I recognize that any death benefit payable under these annuities or the mutual funds will be paid to the beneficiaries as described on this form.

First Name (Please print)

Last Name (Please print)

Your Signature

Today's Date (mm/dd/yyyy) / / 20

NOTARY PUBLIC CERTIFICATION

State

County

Expiration Date (mm/dd/yyyy) / / 20

On the date noted below, the subscriber known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

Notary Public's Signature

Today's Date (mm/dd/yyyy) / / 20

FOR NOTARY IN MASSACHUSETTS ONLY
Indicate the type of identification.

☐ Valid federal or state ID.

☐ Testimony of a credible witness.

☐ Personal knowledge of the subscriber.

In this space, the Notary Public must provide his/her notarial number and the date the appointment expires. Provide the notarial seal if outside New York state.

OR

PLAN REPRESENTATIVE CERTIFICATION

By signing, you are certifying you witnessed the spouse's signature.

Plan Representative's Signature

Today's Date (mm/dd/yyyy) / / 20

Plan Representative's Name (please print)

Title

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BENEFICIARY DESIGNATION FORM

Please review carefully to ensure your application is complete; failure to do so may delay processing.

YOUR CHECKLIST

- ☐ Provide all the personal information requested and choose your beneficiaries.
- ☐ Initial any changes made within the form and be sure to sign and date the agreement in Section 6.
- ☐ Complete the "Additional Requirements Based on Marital Status" section. If you are single, complete Section 7A; if you are married and have not designated your spouse as a primary beneficiary of at least 50% of the benefit, or the percentage required by your plan, your spouse must complete Section 7B in front of a Notary Public or your current employer's plan representative.
- ☐ If applicable, attach a signed and dated page to list special provisions for deceased beneficiaries.

Original documents are required. Faxes cannot be accepted.

PLEASE RETURN COMPLETED FORM TO:

STANDARD MAIL:
TIAA-CREF
P.O. Box 1268
Charlotte, NC 28201-1268

OVERNIGHT MAIL:
TIAA-CREF
8500 Andrew Carnegie Blvd
Charlotte, NC 28262

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BENEFICIARY DESIGNATION FORM

BENEFICIARY PROVISIONS

1. **Effectiveness**
   This *Designation of Beneficiary* is effective for each annuity contract and certificate listed by number or by definition of contracts as stated in the Annuity Numbers section. If the beneficiary designations are satisfactory by TIAA-CREF's standards and the designations are accepted by TIAA-CREF, the designations will be effective from the date the form was received in good order by TIAA-CREF.

2. **Immediate Annuity under a Two-Life Option**
   If you own an Immediate Annuity under a Two-Life Option, you have already provided for benefits at your death for the second annuitant. Therefore, your second annuitant should not be named as a beneficiary. If you do designate your second annuitant, TIAA-CREF will remove that person from the contract's designation. Your confirmation will display this change.

3. **Order of Payment and Division of Benefits**
   a. Unless otherwise stated: At your death (or the last surviving annuitant's death under a Two-Life Annuity), any benefits due will be paid to a beneficiary if he or she is then living. If a class of beneficiaries contains more than one person, benefits due to the beneficiaries in such class at your death (or the last surviving annuitant's death under a Two-Life Annuity) will be paid in accordance with the proportions stated. If a beneficiary predeceases you (or the last surviving annuitant under a Two-Life Annuity), the proportion of the benefits that would have otherwise been apportioned to such deceased beneficiary shall instead be divided to the other beneficiaries who survive you (or the last surviving annuitant under a Two-Life Annuity).
   b. If all beneficiaries predecease you (or the last surviving annuitant under a Two-Life Annuity), all benefits will be payable to your estate (or the estate of the last surviving annuitant under a Two-Life Annuity).

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BENEFICIARY DESIGNATION FORM

ADDITIONAL PROVISIONS

Provision: "Per stirpes" provision applied to a beneficiary means that if you check 'per stirpes' and the named beneficiary predeceases you, the monies which would have been paid to that beneficiary will be divided proportionately among his/her children (if any). If there are no living children for that beneficiary, their portion will be paid in proportion to the remaining beneficiaries in that class. In the event there are no other beneficiaries, we will pay your Estate.

Example:

John Doe – your son with a 100% designation per stirpes

Jane Doe – your daughter with a 100% designation per stirpes

John predeceases you. Then John's portion will be paid to his children equally. If John has no children, his share will then be paid to Jane. If both John and Jane predecease you and there are no children, we will pay the contingent beneficiaries you designate. In absence of any contingent beneficiaries, we will pay your Estate.

4. **If a Testamentary Trust is Designated as Beneficiary:**
   a. TIAA-CREF will not accept or be obliged to inquire into the terms of any will or of any trust affecting the annuity contract/certificate or its death benefit and shall not be charged with knowledge of terms thereof.
   b. TIAA can only accept a testamentary trust if you give us the create date of the will at the time of the designation. A designation of Will is not acceptable.
   c. If benefits become payable to a testamentary trust and (i) the will is not presented for probate within 90 days following the date of your death (or the death of the last surviving annuitant in a Two-Life Annuity); or (ii) the will has been presented for probate within the aforesaid 90 days and no qualified trustee makes claim for the benefits within nine months after your death (or the death of the last surviving annuitant in a Two-Life Annuity); or (iii) if evidence is furnished and is satisfactory to TIAA-CREF within such nine-month period that no trustee can qualify to receive the benefits, payment shall be made to the successor beneficiary(ies), if any such beneficiary(ies) (is)are designated and survive you (or the last surviving annuitant in a Two-Life Annuity): otherwise to your estate (or the estate of the last surviving annuitant).
   d. If benefits become payable to an inter vivos trust and (i) the trust agreement is not in effect; or (ii) no trustee can qualify to receive the benefits; or (iii) the qualified trustee is not willing to accept the benefits, payments shall be made to the successor beneficiary(ies) as designated, if any such beneficiary(ies) are designated and survive(s) you (or the last surviving annuitant in a Two-Life Annuity); otherwise to your estate (or to the estate of the last surviving annuitant).
   e. Payment to, and receipt by, said trustee, said successor beneficiary(ies) or said estate, as provided for in (b) and (c) above, shall fully discharge TIAA-CREF for all liability to the extent of such payment. TIAA-CREF shall have no obligations as to the application of funds so paid and shall, in all dealings with said trustee or with said executor(s) or administer(s), including but not limited to any consent, release or waiver of interest, be fully protected against the claims or demands of any other person(s).

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BENEFICIARY DESIGNATION FORM

FRAUD WARNING

FOR YOUR PROTECTION, WE PROVIDE THIS NOTICE / WARNING REQUIRED BY MANY STATES

This notice/warning does not apply in New York.

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or a statement of claim for insurance benefits containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may be subject to criminal penalties, including confinement in prison, and civil penalties. Such action may entitle the insurance company to deny or void coverage or benefits.

Colorado residents, please note: Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Virginia and Washington, DC residents, please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.