

**MABANK
INDEPENDENT
SCHOOL
DISTRICT**

**NEW EMPLOYEE
PACKET
2016-2017**

Mabank ISD

Direct Deposit Request

Name _____
(Print as shown on Payroll Check)

Date to begin automatic deposit: _____

Provide the following information for the bank account to which you would like your payroll check deposited:

Bank Name: _____

Bank Address: _____

Routing Number: _____

(Found at the bottom left of your checks and deposit slips)

Account Number: _____

(Found at the bottom middle of your checks and deposit slips)

Type Account: Checking _____ Savings: _____

I hereby authorize Mabank ISD to initiate debits or credits, as needed for payroll transactions to the bank account named above.

Signed: _____

Date: _____

**PAY DAY SCHEDULE
MONTHLY
2016-2017**

BEGINNING OF PAY PERIOD	END OF PAY PERIOD		PAYDAY
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06/04/16	07/01/16		07/14/16
07/02/16	07/29/16		08/15/16
07/30/16	08/26/16		09/15/16
08/27/16	09/23/16		10/14/16
09/24/16	10/28/16		11/15/16
10/29/16	12/02/16		12/15/16
12/03/16	12/30/16		01/13/17
12/31/16	01/27/17		02/15/17
01/28/17	02/24/17		03/15/17
02/25/17	03/24/17		04/13/17
03/25/17	04/28/17		05/15/17
04/29/17	05/26/17		06/15/17

Salary pay is annualized and paid out over 12 months. The beginning and ending pay period dates are for extra or additional pay.

Employee Access Information

For Employees

- From the Mabank ISD web page, click on **EMPLOYEE ACCESS** located in the center of the page under **Faculty and Staff**
- Use your login name and password provided by payroll (this may be different than your student access or educator access log on)
- Your personal screen will appear
- At the top of your screen you will see headings for available information. As you click on the headings you will see real time data that is used for calculating your paycheck. Your personal information and settings should be checked for accuracy. Contact the payroll office for corrections.
- **General** information has a district calendar with important dates noted. Passwords can be changed in this area. Report options will allow you to print your paycheck stub.
- **Time Off** information is exported directly from the AESOP program on a weekly basis. Available leave and activity can be checked here and in AESOP for accuracy. Contact your campus secretary if discrepancies are found.
- **Payroll** information contains data used to calculate your paycheck and your pay history. The paycheck estimator can be used to calculate your pay with different scenarios. Your direct deposit and W-4 information can be checked for accuracy here.

MABANK INDEPENDENT SCHOOL DISTRICT

Time Off Information

Employees earn ½ day State Leave for each 18 days of work and ½ day Local Leave for each 45 days of work. A total of 7 Leave days earned for 180 workdays. These 7 Leave days will be available to use before they are earned. If excessive absenteeism causes your total days worked to fall below 180 workdays (prorated amount if hired during the year) your paycheck will be adjusted in order to prevent you from being overpaid. Any Leave days not earned will be deducted from your June paycheck. When all paid leave is exhausted, employees may be eligible to apply for additional leave types.

Your campus secretary tracks your absences through the AESOP program. You will be required to report all absences via telephone or computer in AESOP. Information and instructions for AESOP will be furnished in your personnel information packet. Check with your campus secretary for campus procedure for absence reporting.

Extended absences (5 or more days) due to illness are subject to FMLA and must be processed immediately.

Mabank ISD Board Policy concerning usage of Leave is available on the Mabank ISD website under WEBLINKS. (www.mabankisd.net)

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name

Employee ID#

Employer Name

Employer ID#

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

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee

Date

Information about Social Security Form SSA-1945

Statement Concerning Your Employment in a Job Not Covered by Social Security

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

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

Employers must:

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

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

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/form1945. Paper copies can be requested by email at oplm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

NOTICE CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because you have recently become covered under TRS-ActiveCare, your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations "under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced;
- Your employment ends for any reason other than your gross misconduct; or
- Your participating entity fails to pay all premiums for at least 90 days.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your spouse; or
- Your spouse's participating entity fails to pay all premiums for at least 90 days.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated;
- The child stops being eligible for coverage under the Plan as a "dependent child"; or
- The parent-employee's participating entity fails to pay all premiums for at least 90 days.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days of the later of (1) the date on which the qualifying event occurs; or (2) the date coverage would have been lost as a result of the

qualifying event. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment, reduction of the employee's hours of employment, or failure of the participating entity to pay all premiums for at least 90 days, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment, reduction of the employee's hours of employment, or failure of the participating entity to pay all premiums for at least 90 days, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Contact your employer and/or

the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIP AA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.



Medicaid Subsidy (HIPP) Notice

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

As indicated below, Texas provides premium assistance for State Medicaid, but not for CHIP.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility.

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>
Phone: 1-855-692-5447

ALASKA – Medicaid

Website:
<http://health.hss.state.ak.us/dpa/programs/medicaid/>
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants>
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid

Medicaid Website: <http://www.colorado.gov/>
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: <https://www.flmedicaidtplrecovery.com/>
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website:
www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid

Website: <http://www.in.gov/fssa>
Phone: 1-800-889-9948

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: <http://www.lahipp.dhh.louisiana.gov>
Phone: 1-888-695-2447

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/OIAS/public-assistance/index.html>
Phone: 1-800-572-3839

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/MassHealth>
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid

Website:
<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website:
<http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website:
http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx
Phone: 1-877-255-3092

NEVADA – Medicaid

Medicaid Website: <http://dwss.nv.gov/>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: www.dhhs.nh.gov/ombp/index.htm
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 1-800-356-1561
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website:
http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid and CHIP

Website: <http://www.ncdhhs.gov/dma>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website:
<http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-800-755-2604

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://www.oregonhealthykids.gov>
<http://www.hijossaludablesoregon.gov>
Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid

Website: <http://www.dpw.state.pa.us/hipp>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Website: <http://health.utah.gov/upp>
Phone: 1-866-435-7414

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>
Medicaid Phone: 1-800-432-5924
CHIP Website: <http://www.famis.org/>
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website:
<http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

Website: <http://www.badgercareplus.org/pubs/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website:
<http://health.wyo.gov/healthcarefin/equalitycare>
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 11-30-2013)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
All employees.

Some employees. Eligible employees are:

- With respect to dependents:
We do offer coverage. Eligible dependents are:

We do not offer coverage.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.**

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

SIGNATURE PAGE

- I have viewed the Workers Compensation Safety Video located on the Mabank ISD homepage on the STAFF RESOURCES link.
- I have received a copy of the TRS-Active Care Continuation Coverage Rights under COBRA.
- I have received a copy of the Medicaid Subsidy Notice (HIPPA).
- I have received the Affordable Care Act Marketplace Coverage Options.

Employee signature _____ Date _____



Mabank ISD
Employee Wellness Center
Membership Form



Employee Contact (person responsible for the account)

First Name: _____ Last Name: _____

Campus: _____

School E-mail: _____

Additional Family Members (high school and above)*

First Name	Last Name	M/F	Age	Date of Birth	Relationship to Employee
				____/____/____	
				____/____/____	
				____/____/____	
				____/____/____	
				____/____/____	

*I acknowledge that the individuals listed here are permanent residents of my household. _____

Membership Type

Employee \$20/mo Employee + 1 \$30/mo Family \$40/mo

Months of Deduction thru July x _____

Activation Fee (if new member) + \$20 _____

Total Deduction current month thru July =\$ _____

I have reviewed the above information, represent it to be accurate, and authorize Mabank ISD to deduct _____ from my monthly paycheck thru July.

Rates are subject to change on August 1 of each year. Notification of the rate charges will be made to employees prior to the end of the current school year

Employee Signature

Date

Approved by MISD Business Office

Date



Mabank ISD
Employee Wellness Center
Membership Form



Terms & Conditions

Annual membership in the MISD Wellness Center is offered to all employees and their families (spouses or children grades 9 and above). Employees may enroll at any time, and memberships convert to an annual membership on the next September 1st. This agreement will renew automatically, without notice, annually on September 1st, unless a written cancellation notice is received by MISD prior to August 1st each year.

A \$20 activation fee is required to join the Mabank ISD Wellness Center. Membership dues are paid either monthly in advance by payroll deduction, or annually in advance by cash or check.

Access cards will not be issued to high school students. They will need to be accompanied by their parents or use their card. Notification must be given to MISD concerning all lost cards. A replacement fee of \$5.00 will be charged for any lost card.

This membership may not be given, sold, assigned, shared, or otherwise transferred to any other person.

While on or about the premises, members promise to abide by all terms, conditions and policies of MISD and to conduct himself/herself in a peaceful manner at all times. Members understand that failure to act in accordance with these conditions could result in being expelled from the premises and at the same time cause forfeiture of any membership fees paid or contractually obligated. Members hereby release and hold harmless MISD, its agents, owners, and employees from all claims, demands, injuries, damages, actions, or causes of action within.

Employee acknowledges that injuries are not covered by worker’s compensation coverage, and that participation in the MISD Wellness Center is not required as a condition of employment and is beyond the normal course or expectations of their job.

Please have each member listed on the opposite side initial and sign below indicating they have read and agree to the policies stated above.

**MABANK ISD
EDUCATION FOUNDATION
PAYROLL DEDUCTION
AUTHORIZATION**

I, _____ request \$_____ be deducted each month from my
Mabank ISD payroll check to be forwarded to the Mabank ISD Education Foundation.

I understand this payroll deduction will remain in effect until I submit a change in writing
to the Mabank ISD Payroll Department.

Employee Signature

Date