SPCR HR- 02/2012

Wyoming State Parks & Cultural Resources

****NEW HIRE INFORMATION FOR PERMENANT EMPLOYEES****

1. **EMPLOYEE NAME –please print:** _____
(Exactly as printed on Social Security Card)

DATE OF BIRTH: _____

EEOC INFORMATION:
Race Code: White____ Black____ Hispanic____ Asian or Pacific Islander ____
American Indian or Alaskan Native____

EMERGENCY Contact Name: _____ Phone Number _____

MAILING ADDRESS for payroll and W-2: _____
_____

2. Work Location: _____
3. **START DATE:** _____ **MONTHLY** or **HOURLY RATE:** _____
4. *COMPLETE THE FOLLOWING FORMS (check when completed):*

____ *APPLICATION*

____ *I-9 Employment Eligibility Verification MUST BE COMPLETED AND SIGNED BY EMPLOYEE AND SUPERVISOR PRIOR TO EMPLOYEE STARTING TO WORK!! COPIES OF THE DOCUMENTS USED MUST BE ATTACHED.*

____ *W-4 [Withholding Allowance Certificate]*

____ *PAYROLL DIRECT DEPOSIT AND/OR 1199A DIRECT DEPOSIT*

____ *PM-14 NOTICE & ACKNOWLEDGMENT*

____ *DRUG FREE WORKPLACE REQUIREMENTS*

____ *OVERTIME CHOICE OF COMPENSATION FORM*

____ *MOTOR POOL AND WYDOT FUEL FORMS *ONLY IF REQUIRED TO DRIVE AND/OR FUEL STATE VEHICLES*

____ *WORK PLACE VIOLENCE ACKNOWLEDGMENT*

____ *ETHICS ACKNOWLEDGMENT*

____ *ANTI-DISCRIMINATION ACKNOWLEDGMENT*

____ *INFORMATION TECHNOLOGY ACKNOWLEDGMENT*

____ *E-MAIL POLICY ACKNOWLEDGMENT*

____ *INTERNET ACCEPTABLE USE POLICY ACKNOWLEDGMENT*

____ *REFERENCE POLICY*

____ *RETIREMENT*

*INSURANCE: *Forms must be filled out if electing or declining.*

____ *NEW EMPLOYEE INSURANCE CHECK LIST*

____ *Insurance Acknowledgment Form*

____ *INSURANCE FORMS:*

___ *HEALTH, DENTAL, LIFE*

___ *OPTIONAL: VISION AND SHORT- OR LONG - TERM DISABILITY*

____ *FLEXIBLE SPENDING*

HR USE ONLY

PORG: _____

POSITION # _____

CLASS: _____

EE ID# _____

ALT ID# _____

OT Choice: _____

Check____ OR Auto Deposit_____

New Hire_____ OR Rehire_____

4. *Questions about the forms in this hire packet? Human Resources: (307) 777-3631; HR Fax: (307) 777-6381*

5. *SUPERVISOR'S SIGNATURE:* _____

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

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

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

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

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

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

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

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

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

☐ 1. A citizen of the United States

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

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

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

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

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

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

Preparer and/or Translator Certification (check one):

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

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

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

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

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

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

STOP *Employer Completes Next Page* STOP

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

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

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

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

Additional Information

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

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

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

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

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

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

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

You must provide a copy of your social security card for payroll identification.

If you do not have a social security card, call 1-800-772-1213 to request one or to get a replacement.

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

2020

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 widow(er))
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4); **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld . . . . . ▶ ☐

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

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **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

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2020 if you meet both of the following conditions: you had no federal income tax liability in 2019 **and** you expect to have no federal income tax liability in 2020. You had no federal income tax liability in 2019 if (1) your total tax on line 16 on your 2019 Form 1040 or 1040-SR is zero (or less than the sum of lines 18a, 18b, and 18c), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2020 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 16, 2021.

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

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Have dividend or capital gain income, or are subject to additional taxes, such as the additional Medicare tax;

3. Have self-employment income (see below); or

4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

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

Specific Instructions

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

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

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

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

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

Step 3. Step 3 of Form W-4 provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2020 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

Step 2(b)—Multiple Jobs Worksheet *(Keep for your records.)*

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

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2020 itemized deductions (from Schedule A (Form 1040 or 1040-SR)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . 1 $

2 Enter:
- $24,800 if you're married filing jointly or qualifying widow(er)
- $18,650 if you're head of household
- $12,400 if you're single or married filing separately

. . . . . 2 $

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

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

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

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 possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

Married Filing Jointly or Qualifying Widow(er)

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	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

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	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

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	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

STATE OF WYOMING
STATE AUDITOR'S OFFICE – PAYROLL DIVISION
AUTOMATIC PAYROLL DEPOSIT

Agency Name: State Parks & Cultural Resources Agency Number: 024

Employee Name: _____

_____New Enrollment*
_____Change of Account, Amount and/or Financial Institution
_____Cancel Participation
_____Does Not Wish to Participate in Direct Deposit at this Time

***Checking: A Voided Check, or Completed 1199 Form Must Be Attached For Every Account**

***Savings: Must Provide Bank Verification or Submit an 1199 Form**

Deposit my **NET PAY** each payday in the _____
(Name of Financial Institution)
Checking ___ Account Number _____

Savings ____ Account Number _____

Enter Additional Direct Deposit Accounts Below

Deposit $_____ each payday in the _____
(Name of Financial Institution)
Checking ___ Account Number _____

Savings ____ Account Number _____

Deposit $_____ each payday in the _____
(Name of Financial Institution)
Checking ___ Account Number _____

Savings ____ Account Number _____

Deposit $_____ each payday in the _____
(Name of Financial Institution)
Checking ___ Account Number _____

Savings ____ Account Number _____

Employee Signature: _____ Date: _____

Standard Form 1199A (EG)
(Rev. June 1987)
Prescribed by Treasury
Department
Treasury Dept. Cir. 1076

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY STATE ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER

Prefix Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*

- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☐ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*

TYPE	AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.

THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

STATE OF WYOMING

DEPARTMENT OF ADMINISTRATION AND INFORMATION
Human Resources Division

Mark Gordon
Governor

Patricia Bach
Interim A&I Director

Erin Williams
Interim HRD Administrator

PM-14

Notice & Acknowledgement

I, _____, acknowledge that I have had the opportunity to read and review the State of Wyoming Personnel Rules (http://personnel.state.wy.us/). I have been advised as to where the Rules are located and I understand that I have access to them.

I understand that I am a/an (circle one) Emergency, Non-Permanent, Probationary, Provisional, Time-Limited or Temporary employee as described in the Personnel Rules, and I am an at-will employee who has no expectation of continued employment.

I further understand that I may be dismissed at any time during the probationary period without cause or reason.

_____
Signature

_____
Date

EMERSON BUILDING-ROOM 127 • 2001 CAP ITOL AVENUE • CHEYENNE, WY 82002-0060
TELEPHONE: (307) 777-6173 FAX: (307) 777-6562

DRUG-FREE WORKPLACE REQUIREMENTS

Notice is hereby given in conformance with the Drug-Free Workplace Act of 1988 (Pub. L. 100-690, Title V, Subpart D) that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited.

Employees engaged in the performance of grants received directly from a Federal Agency are notified that as a condition of employment, they will:

a) Abide by the terms of this NOTICE; and
b) Notify the Department of State Parks and Cultural Resources of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction.

Appropriate personnel action, up to and including termination, will be taken against any employee convicted of a violation of any criminal drug statute.

The Department of State Parks and Cultural Resources will maintain at its Personnel Office in Cheyenne, Wyoming, a referral list of available drug counseling/rehabilitation programs.

_____ _____

Employee Initials Date

FROM: _____
(Please print your name)

DATE: _____

SUBJECT: OVERTIME COMPENSATION

In accordance with the rights provided to me under the Fair Labor Standards Act, I hereby acknowledge my option to choose between being paid for overtime or receiving compensatory time off at the rate of 11/2 hours for each hour I have worked in excess of 40 hours. Due to economic considerations, the Department requests your cooperation to accept compensatory time in lieu of payment. This applies to any hours in excess of forty (40) within any workweek. Please check the appropriate box below to record your election:

____ TO BE PAID

____ TO RECEIVE COMPENSATORY TIME AT 1 ½ HOURS

Employee Signature: _____ Date: _____

cc: Personnel File

EMPLOYEE INFORMATION FOR MOTOR POOL

Wyoming A&I ADMINISTRATION & INFORMATION

Name: _____ Title: _____

Agency Number & Name: _____ Division: _____

Work Address: _____ Work Phone: _____

City/Zip: _____ Cell Phone: _____

Fax Number _____

E-mail address: _____ Emergency Contact: _____

Last 6 of SS# for Wright Express fuel access: _____ ***(form will be shred after input)***

Driver's License Number: _____ State: _____ Exp. Date: _____

Will you be checking vehicles out from our Pool? Yes _____ No _____

Will you have a permanent assigned vehicle? Yes _____ No _____

Please complete this form and e-mail **ai-motorpool@wyo.gov** OR fax (307) 635-0911 OR drop off at A&I Motor Pool at 723 West 19th Street – Cheyenne, WY 82002

If you have any questions, please (307) 777-7247 or (800) 442-2375

Revised 12/2017 des

WYDOT – FUELMASTER MANAGEMENT REQUEST FORM

Purpose: This form allows state employees, vendors or contractors to request the use and access of Fuelmaster sites across the State of Wyoming. This form will be used by WYDOT's Financial Services Fuel Management program to authorize and charge state parties in their fuel usage. Information will be collected and analyzed to ensure appropriate allocations of fuel and charges are calculated appropriately. Drivers License number is a requirement to access the Fuelmaster fuel stations. The Supervisor can either send the request via e-mail **or** sign the document and mail it. A Supervisor is the approval authority for the Form. Send the form to fuelmaster@dot.state.wy.us if e-mailing.

☐ **ADD** ☐ **Modify** ☐ **Delete**

I. APPLICANT INFORMATION

a. APPLICANT NAME (*Last, First Middle*):			
b. AGENCY:		**c. AGENCY NUMBER:**	
d. DEPARTMENT:			
e. PHONE NUMBER:			
f. EMAIL:			

II. APPLICANT SUPERVISOR INFORMATION

a. SUPERVISOR NAME (*Last, First Middle*):		**b. REQUIRED DATE (*MM/DD/YYYY*):**	
c. AGENCY:		**d. AGENCY NUMBER:**	
e. DEPARTMENT:			
f. PHONE NUMBER:			
g. EMAIL:			

III. DRIVERS LICENSE NUMBER

The Drivers License Number is required to use the Fuelmaster stations across the state.

a. State	b. Drivers License Number	c. Wyoming State Employee ID

Explanation: The Fuelmaster System will only accept 9 digit numbers. In some states a license number is longer than 9 digits and has letters, the Fuel Management Staff will take the following action to the license number:

Out of State

Driver License Number: 1A2B34568Z1 Modified to: 102034568

Wyoming

Driver License Number: 123456-123 Modified to: 123456123

The Out of State Drivers License Number is modified to meet the requirements of the Fuel Master system by setting all letters to ZERO and removing the digits larger than 9 from the right. The dash is removed from the Wyoming Drivers License Number.

III. SIGNATURES (A signature is not required if e-mailed. The supervisor's email address must match this form).

Applicant's Signature		
a. Signature:	**b. Date (*MM/DD/YY*):**	
Supervisor's Signature		
a. Signature:	**b. Date (*MM/DD/YY*):**	

IV. FUELMASTER MANAGEMENT STAFF (INTERNAL ONLY)

a. Date Entered (*MM/DD/YY*):		**b. Drivers License Number Entered:**	
c. Previous Date Entered (*MM/DD/YY*):		**d. Staff Initials**	

V. Points of Contact (*Phone Numbers and E-Mail Address*)

Fuel Management Questions: (307) 777-4372 **Fax Number: (307) 777-3858**

E-Mail Address (*send form to*): **fuelmaster@wyo.gov**

VI. REMARKS/SPECIAL INSTRUCTIONS

State Parks & Cultural Resources
Violence in the Workplace Plan

Violence in the workplace can happen anywhere resulting in a multitude of negative outcomes such as property damage, loss of work time and even death just to name a few. Everyone deserves a safe workplace. We cannot create a flawless job site, however, by taking precautionary steps we can help reduce the possibility of violence by making all employees more aware of this alarming occurrence.

The department is cognizant of its responsibility to provide a safe work environment. While respecting individual rights is important, priority certainly must be given to the safety and welfare of all employees. It is for this reason the department wishes to immediately institute the following conditions:

1. All employees, with the exception of law enforcement personnel within the Division of Parks and Historic Sites, and any/all employees who reside in state provided housing, and sites who's mission consists in part of displaying historical weapons in exhibit form, are strictly prohibited from possessing deadly weapons while occupying any facility owned, leased or rented by any State Parks & Cultural Resources entity. This also applies to State motor vehicles and any other equipment. W.S. 6-1-104 (iv), states "Deadly weapon" means but is not limited to a firearm, explosive or incendiary material,… or other device or substance, which in the manner it is used or is intended to be used is reasonably capable of producing death or serious bodily injury." Any employee found to be in violation of this directive will be subject to disciplinary action for any or all of the following: Insubordination; Misconduct and Unsatisfactory Work Performance. The department will use all available resources in determining and applying appropriate disciplinary action.
2. Employees communicating threats to other employees, clients, vendors or constituents will be subject to disciplinary measures for any or all of the following: Insubordination; Misconduct and Unsatisfactory Work Performance. All management positions are responsible for insuring incidents of this nature are reported to the Human Resource Manager immediately. At that time the Human Resource Manager will conduct an investigation of such occurrence prior to any disciplinary action. Information will be sought from all known parties. Committee formation is strictly at the discretion of the Department Director. Such committee, if determined necessary, will consist of the following;
    a. Supervisor (Of the alleged employee)
    b. Division Administrator (Of the alleged employee)
    c. Human Resource Officer
    d. Administrative Services Administrator
    e. Department Director

Malicious complaints of threats in the workplace may result in disciplinary action against the accuser.

3. In the event threats are communicated by clients, constituents or another employee(s), employees should not respond in kind. Remain calm and assuming the threat is verbal in nature, contact your supervisor and/or the section manager and division administrator. If the conflict involves a weapon, depending on office location, contact your city or county law enforcement officials. Division administrators should make sure each office site is familiar with this process. If escalation occurs evacuation plans should be utilized. Staff awareness is of great importance. The Barrett Building currently has an evacuation plan in place. The contents of this plan must be shared with all existing and future staff. If not previously developed, offices outside of the Barrett Building and Cheyenne must generate a plan. Natural disaster evacuation plans should serve hostile action as well.
4. Human Resources will implement and coordinate a visual aide training program focusing on preventing workplace violence. All employees will be required to attend. Inclusion of written material in new employee orientation packets as well as dispersed to all employees will take place.

WORKPLACE VIOLENCE ACKNOWLEDGMENT FORM

I, _____, acknowledge that I have had the opportunity to read
(Please Print Name)
and review the Department of State Parks and Cultural Resources Workplace Violence Plan. In addition, I received a personal copy of such plan in my new employee packet and had an opportunity to discuss the contents with Human Resources. I am also aware if I have any questions regarding the Workplace Violence Plan or have any other concerns I can also contact Human Resources at 777-7010 or 777-3631.

_____
Signature of Employee

_____
Date

9/99

State Parks & Cultural Resources Ethics Philosophy

As an agency of the Executive Branch of Wyoming State Government, the Department of State Parks & Cultural Resources and each of its employees are expected to adhere to all provisions of Executive Order 1997-4, State of Wyoming Executive Branch Code of Ethics. The Department of State Parks & Cultural Resources will offer guidance and assistance to employees concerning questions on ethics and will provide interpretations of Executive Order 1997-4. The department will also investigate reports of ethics violations; and will protect the privacy of employees filing reports as well as those accused until the accusations are demonstrated to be true. The department will penalize or appropriately discipline any employee found to have violated Executive Order 1997-4 as well as any employee who attempts to or actually participates in reprisals.

General Provisions

Each Department of State Parks & Cultural Resource employee is expected to serve the citizens of Wyoming with integrity and honesty. Engaging in activities which are improper or could be perceived as improper is prohibited. It is important to avoid any conduct which compromises or has the potential to compromise the department and the State of Wyoming. Executive Order 1997-4 will serve as the general standard by which conduct will be measured. Department employees should consider whether their activities can be explained and supported before the media, Department Director or the Governor. It is the responsibility of the employee to seek guidance from their immediate supervisor or the first level supervisor who is not involved in the alleged violation if they are uncertain as to the proper course of action.

Responsibilities

Department of State Parks & Cultural Resource employees are expected to attend a training course on Executive Order 1997-4. Each employee will sign a form acknowledging they were in attendance and received a copy of the Executive Order and the Department's ethics procedure. This form will be kept in the department Human Resource office and a copy will be sent to The Department of Administration and Information, Human Resource Division. A copy of the department ethics procedure and related training material will be included in the orientation of all new employees. Department Supervisors are expected to ensure their employees have been advised in Executive Order 1997-4.

Interpretation

Any employee that has a question regarding an action, decision or situation (actual or hypothetical) that is in or may be in conflict with the Ethics Order is expected to submit the specifics in writing to the Human Resource Manager. All questions will be reviewed

by the Director or designee and the Human Resource Manager. When a decision has been made a decision in writing will be given to the employee. A copy of all decisions will be retained by the Human Resource Manager and used for future questions, circumstances and interpretation.

Reporting

Any employee having knowledge of a violation of the ethics order has a responsibility to report such information to their immediate supervisor or to the first level supervisor who is not involved in the alleged violation. The report of the violation should be made in a timely manner and in writing. The supervisor will conduct an inquiry into the alleged violation if it concerns an employee under their direct supervision. If the violation should concern an employee under the supervision of another supervisor, that supervisor will conduct the inquiry after the report has been received. Such inquiry shall be conducted within ten (10) working days of the receipt of the report.

Upon completion of the inquiry the supervisor shall submit the findings to the Division Administrator. The Division Administrator will review the findings and make a determination as to whether the violation is legitimate considering all factors. The administrator has ten (10) working days to review the findings and determine whether to proceed.

If it is determined the violation is legitimate the Division Administrator will deliver the report and finding to the Human Resource Manager. The Director or designee and the Human Resource Manager will review the findings and make a determination as to what, if any, type of disciplinary action is necessary. The Director and Human Resource Manager have twenty (20) working days to render a decision regarding disciplinary action. The Director's decision is final.

The Director may seek input from the Attorney General's Ethics Committee at any time during the review process. This committee has been assigned the responsibility to review any questions or violations of the Executive Order on Ethics. The committee was established to provide consistency in interpretation of the executive order.

Investigations

All reports of suspected ethics violations brought to the attention of the Department shall be investigated. The Department reserves the right to appoint an investigating officer from either within or outside the Department and may request the assistance of Attorney General in appointing an officer. All efforts will be made to protect employees who have reported suspected violations in addition to those employees having been accused of suspected violations, yet to be proven, to the maximum extent possible.

Employees are required to cooperate fully with appointed or designated investigating officers. If a Department employee is interviewed or asked to provide a written statement, the information provided shall be truthful and accurate. Each investigation will be concluded promptly and the employees involved will be informed of the investigations outcome. Any employee who attempts to obstruct an investigation or is found to give false testimony shall be subject to disciplinary action pursuant to the Personnel Rules of the Executive Branch of Wyoming State Government.

Confidentiality

All efforts will be made to protect the identity of employees who have reported suspected violations in addition to those employees accused of suspected violations, yet to be proven, to the maximum extent possible. Reprisals are prohibited against any employee reporting a suspected violation, or who testifies, assists or participates in an ethics violation investigation. Attempted reprisals shall be reported utilizing the same procedures as used when reporting ethics violations. Reprisals are subject to disciplinary actions pursuant to the Personnel Rules of the Executive Branch of Wyoming State Government.

Penalties

Employees found to have violated the ethics order are subject to disciplinary action as defined in the Personnel Rules of the Executive Branch of Wyoming State Government. Each situation will be judged on its own merit. Appropriate and final discipline will be administered by the Department Director. Penalties may include but are not limited to verbal reprimands, letters of counseling and/or expectations, written reprimands, suspension with or without pay, or termination of employment. Malicious and/or frivolous reports of ethics violations may result in disciplinary action being initiated against the accuser. Appropriate cases may be referred for possible criminal prosecution.

STATE OF WYOMING
OFFICE OF THE GOVERNOR

JIM GERINGER
GOVERNOR

STATE CAPITOL
CHEYENNE, WY 82002

STATE OF WYOMING

EXECUTIVE DEPARTMENT

EXECUTIVE ORDER

1997- 4

Pursuant to the authority vested in the Office of the Governor of the State of Wyoming, I, Jim Geringer, Governor of the State of Wyoming, hereby issue this Executive Order adopting the following Executive Branch Code of Ethics in the interest of better serving the citizens of the State of Wyoming through the provision of ethical standards applicable to all public officials, elected officials, appointees, and employees of the Executive Branch of the State of Wyoming. This Code of Ethics does not apply to employees of the University of Wyoming or community colleges.

STATE OF WYOMING

EXECUTIVE BRANCH CODE OF ETHICS

1. Purpose. Those who serve the people of the State of Wyoming should do so with integrity. Neither impropriety nor the appearance of impropriety should occur. This Code of Ethics is intended to serve as a yardstick by which the conduct of all who serve in the Executive Branch of the State of Wyoming can be measured.

E-MAIL: governor@missc.state.wy.us
WEB PAGE: www.state.wy.us

TELEPHONE: (307) 777-7434
TDD: (307) 777-7860 FAX: (307) 632-3909

2. **Scope.** This Code of Ethics is applicable to all employment-related activities of public officials, elected officials, appointees and employees of the Executive Branch of the State of Wyoming. The term "public employees" shall be used in this Code of Ethics to include all public officials, appointees (whether or not they receive compensation) and employees of the Executive Branch. This Code of Ethics extends, but does not supersede, those duties and standards of conduct which are delineated in constitution, statute, or rule. In the event of any conflict between this Code of Ethics and any applicable constitution, statute, or rule, the constitution, statute, or rule shall prevail.

3. **Statement on Gender Pronouns.** Throughout this Code of Ethics, gender pronouns are used interchangeably. In cases where there is one individual holding a particular office, the gender pronoun applicable to the person holding that office as of the date of this writing has been used. In all other instances, the drafters have attempted to utilize each gender pronoun in equal numbers, with random distribution.

4. **Administration of this Code of Ethics.** This Code of Ethics shall be administered by each agency of the State of Wyoming in accordance with the following:

A. No agency shall delete any part of this Code of Ethics.

B. An agency head who receives an allegation of a violation of this Code of Ethics shall promptly investigate to determine whether the allegation is true. Allegations which are found to be *de minimis* in nature shall be handled accordingly. If the allegation is true, the agency head shall take appropriate action. For permanent employees, such actions shall be in accordance with the State of Wyoming Personnel Rules.

C. Allegations concerning violations of this Code of Ethics by an agency head or appointee shall be investigated by the Governor or his designee. Allegations which are found to be *de minimis* in nature shall be handled accordingly. If the allegation is true, the Governor or his designee shall take appropriate action.

5. **General Responsibilities.** All public employees shall:

A. Uphold the Constitutions of the United States and of the State of Wyoming.

B. Abide by the laws of the United States and of the State of Wyoming.

C. Carry out the policies and objectives of the State of Wyoming as established by statute, executive order, or rule, while adhering to established standards for work and performance.

D. Work in cooperation with other public employees, and act within the scope of the authority delegated to them.

E. Protect and conserve all property owned, held by, or leased to the State of Wyoming, including public records. [See Wyo. Stat. §§ 16-4-201 through 205.]

F. Be honest and fair in performing public service.

G. Strive to be honorable, courteous, and dedicated to advancing the public good.

H. Avoid conduct that compromises the integrity of the public office or creates the appearance of impropriety.

6. **Prohibited Activities.** Except as provided in Section 7, no public employee shall engage in:

A. Any activity which constitutes a conflict of interest with her employment. Such prohibited conduct includes, but is not necessarily limited to:

i. Using public office or public employment for personal gain.

ii. Taking official action in a matter in which the public employee has a close personal or financial relationship to a party.

iii. Engaging in activities which conflict with the public employee's official position of employment.

iv. Except as allowed by state law or State of Wyoming Personnel Rules, giving preferential treatment to any person.

v. Except when functioning as an advocate for a client or an agency, making decisions which are not independent and impartial.

B. Conduct which constitutes an abuse of authority. [See Section 7G (Allowed Activities) of this Code of Ethics, for a discussion of activities such as fund raising for recognized organizations which take place on the public employee's own time, which generally do not constitute an abuse of authority.] Conduct which constitutes an abuse of authority includes, but is not necessarily limited to:

i. Using or allowing the use by any private party of official information obtained through or in connection with the public employee's employment by the State of Wyoming, unless such information is available to the general public or unless dissemination is permitted by law.

ii. Awarding, participating in a decision to award or participating in the administration of a State of Wyoming contract, if the employee or any person with whom the employee has a close personal or financial relationship [this includes all members of the public employee's immediate family] is a party to the contract.

iii. Except as provided for in Sections 7A and 7B (Allowed Activities) of this Code of Ethics, acceptance or solicitation by a supervisor of contributions or gifts from subordinate employees. A supervisor may neither solicit nor accept gifts directly or indirectly, for herself or for another person.

iv. Accepting meal expense, lodging or reimbursement for travel or expenses incident to travel on official business from any source other than the State of Wyoming without approval of the agency head. Under no circumstances should a state employee accept items of this nature or gifts if the employee or his agency is involved in an adversarial proceeding with the outside contributing source.

C. Outside employment or any other outside activity which is incompatible with the full and proper discharge of the public employee's duties and responsibilities to the State of Wyoming. [For this reason, all honoraria, fees for speaking engagements, and other such compensation received because of the public employee's position with the State of Wyoming must be deposited in the General Fund.] Activities incompatible with the public employee's duties include, but are not necessarily limited to:

i. Accepting any fee, compensation, gift, payment of expense or any other thing of monetary value in circumstances which create the appearance of a conflict of interest or impropriety, whether or not such conflict of interest or impropriety actually exists.

ii. Receiving a salary or any other thing of monetary value from a private source as compensation for the public employee's services to the State of Wyoming. [This section does not apply to appointees to boards and commissions who do not receive a salary from the State.]

D. The use of or allowing the use of property owned or held by the State of Wyoming [including leased property] for any purpose other than carrying on the official business of the State of Wyoming. Prohibited activities include:

i. Selling or soliciting for personal gain any product or service such as cosmetics, food items, or household goods and services, during official office hours in or on property owned or held by the State of Wyoming. The agency head may make written exceptions to this prohibition, for solicitation on behalf of non-profit organizations.

ii. Transacting personal business during work hours to the extent that it interferes or detracts from the employee's performance of his duties.

iii. Unless required for official business and previously approved by the public employee's supervisor, the use of any facility or building owned or leased by the State of Wyoming as the principal residence or address of any business other than the agency by whom the public employee is employed.

7. Allowed Activities. A public employee may, notwithstanding the provisions of Section 6 above:

A. Solicit or accept voluntary gifts of nominal value or nominal donations. Examples of permissible gifts include voluntary gifts made upon the occasion of marriage, illness, or retirement, or made for charitable or civic purposes.

B. Solicit or accept any thing of monetary value from a friend, parent, spouse, child or other close relative when it is clear from

the circumstances that the motivation for the action is a personal or familial relationship.

C. Accept loans from banks or other financial institutions on customary terms of finance for the proper and usual activities of the public employee, such as home mortgage loans.

D. Accept unsolicited advertising or promotional material of nominal value, such as pens, pencils, note pads, and calendars.

E. Engage in a reasonable amount of communication with family members, day care providers, medical professionals, and similarly situated individuals during the work day. [It is incumbent upon each public employee to learn from her supervisor what is considered reasonable in a particular situation.]

F. Engage in teaching, lecturing, or writing for compensation, when those activities are not related to the public employee's employment by the State of Wyoming. [Each public employee should seek approval from her supervisor prior to engaging in such teaching, lecturing; or writing for compensation.]

G. In his private capacity, solicit persons or organizations to obtain goods, services, grants, or loans on behalf of a recognized charitable or fraternal organization.

8. **Requests for Approval of Activities.** In all cases enumerated above where a public employee is advised to consult with his supervisor prior to engaging in an activity, and in every instance where the public employee is not certain whether a particular activity is allowed by the Code of Ethics, he should consult with his supervisor prior to engaging in the questioned activity. If the public employee requests a written response from the supervisor, the supervisor should respond in writing. This Code of Ethics provides that:

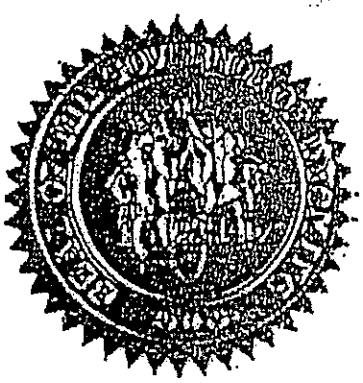
A. No public employee shall be penalized for inquiring of her supervisor regarding prior approval of an activity in which she wishes to engage.

B. If a public employee inquires regarding an activity in which he wishes to engage and his supervisor informs him that engaging in such activity would violate this Code of Ethics, and the public employee then engages in such activity, his supervisor may take appropriate disciplinary action. For permanent employees, such actions shall be in accordance with the State of Wyoming Personnel Rules.

9. Elected Officials. Elected officials occupy their positions as a result of political election. As such, they may participate in political activities. Elected officials must disclose items or services received from outside sources[1] which have a value of $250 or more.[2] The disclosure shall be made by filing a list of the items or services received during each calendar year with the Secretary of State. The filing shall be made by February 15 of the following year. The list shall be divided into items which will be retained by the elected official as a private gift and items which will be left as property of the State of Wyoming when the elected official leaves office.

This Order shall be effective on December 15, 1997, and shall remain in effect until amended.

Given under my hand and the Executive Seal of the State of Wyoming this 3rd day of December, 1997.



Jim Geringer
Governor of the State of Wyoming

[1]Items do not include inherited items. Outside sources do not include family members.

[2]Donations to a political campaign reported pursuant to WYO. STAT. § 22-25-106 are exempt from this reporting requirement.

EXECUTIVE BRANCH CODE OF ETHICS ACKNOWLEDGMENT

By my signature and dating of this document below, I hereby certify I have had an opportunity to read and participate in training concerning the State of Wyoming, Executive Branch Code of Ethics as stated in the State of Wyoming Executive Department, Executive Order 1997-4. I further hereby submit I understand and will abide with those requirements as stated in the State of Wyoming, Executive Branch Code of Ethics with respect to my employment at the State of Wyoming. Moreover, I hereby understand the original of this document signed and dated by me shall be kept in my personnel file and any violation of the State of Wyoming, Executive Branch Code of Ethics by me may result in disciplinary actions being taken against me, up to and including my dismissal from employment, as allowed pursuant to the State of Wyoming Personnel Rules.

_____

Signature

_____

Date

1/98

STATE OF WYOMING
EXECUTIVE DEPARTMENT
EXECUTIVE ORDER

2000 - 4

Pursuant to the authority vested in the Office of the Governor of the State of Wyoming, I, Jim Geringer, Governor of the State of Wyoming, hereby issue this Executive Order adopting the following anti-discrimination policy. This policy is applicable to all employees, officials, appointees, and elected officials of the executive branch of Wyoming State government.

ANTI-DISCRIMINATION POLICY

I. Statement of Policy

The State of Wyoming executive branch strongly disapproves of and does not tolerate discrimination as defined in this policy. Any form of discrimination or harassment that violates applicable state law, including, but not limited to, discrimination or harassment related to an individual's race, religion, color, sex, national origin, age or disability is a violation of this policy and is grounds for discipline, up to and including dismissal. All reported or suspected occurrences of discrimination or harassment shall be promptly and thoroughly investigated. If discrimination or harassment has occurred in violation of this policy, appropriate corrective action shall be taken, including discipline of the offending employee.

II. Prohibited Conduct

This anti-discrimination policy prohibits the following conduct:

A. Sexual Harassment
   1. Definition: Sexual harassment means unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual or gender-based nature when:
      a. submission to such conduct is either explicitly or implicitly made a term or condition of an individual's employment; or
      b. submission to or rejection of such conduct is used as the basis for employment decisions affecting the individual; or
      c. such conduct has the purpose or effect of unreasonably interfering with an individual's work performance, or creating an intimidating, hostile, or offensive working environment.
   2. Examples of inappropriate conduct include, but are not limited to:
      a. threatening or taking adverse employment action if sexual favors are not granted;

b. demands for sexual favors in exchange for favorable or preferential treatment;
c. unwelcome and repeated flirtations, propositions, or advances;
d. unwelcome physical touchings;
e. whistling, leering, improper gestures, or offensive remarks;
f. unwelcome comments about appearance;
g. sexual jokes, or the use of sexually explicit, derogatory, or otherwise offensive language;
h. the display of sexually explicit pictures, greeting cards, articles, books, magazines, photos or cartoons; and
i. any of the above with the use of an employee's access to a state computer, or the state's Internet or e-mail access.

B. Ethnic slurs, racial and religious jokes or derogatory comments based on an individual's race, religion, or ethnic background and any other verbal or physical conduct relating to an individual's race, religion, sex, national origin, age, or disability.

C. Failure to provide reasonable accommodation to an employee who is a qualified handicapped person as set out in Wyo. Stat. § 27-9-105.

D. Basing decisions affecting an individual's employment or any term or condition of the individual's employment on the individual's race, color, national origin, creed, sex, age or because the person is a qualified handicapped person.

E. Any other conduct that violates applicable anti-discrimination law.

F. Retaliation. This policy prohibits retaliation against any employee who opposes a practice prohibited by this policy or who has filed a charge, testified, assisted or participated in any manner in an investigation under this policy.

III. Complaint Procedures

A. Any employee who believes he or she has been discriminated against or harassed by anyone, including a supervisor, co-worker or visitor, in violation of this policy, should report the conduct immediately. An employee may report the conduct to any of the following:
1. the employee's immediate supervisor;
2. any other supervisor in the employee's chain of command;
3. the human resources manager for the agency, division or other unit in which the employee works; or
4. any other individual designated to receive such complaints.

B. Before or in addition to reporting the discrimination or harassment, an employee may, if he or she desires, notify the alleged harasser of the unwelcome conduct and request that the conduct stop immediately.

C. Any supervisor receiving a report of or suspecting harassment or discrimination must immediately report the conduct to the member(s) of management designated to receive such reports.

D. The individual who receives the complaint should contact an Attorney General's Office personnel section attorney upon receipt of a complaint.

IV. Investigations

A. All complaints of discrimination or harassment prohibited by this policy shall be investigated by management as soon as possible after the conduct is reported or suspected.

B. The employee alleging, the employee accused of, and any employee witnessing harassment or discrimination shall cooperate with management in its investigation of the alleged harassment or discrimination.

C. To the extent practicable, all complaints of harassment or discrimination shall remain confidential. It may be necessary, however, to disclose the nature or origin of the complaint to investigate it properly or to take corrective action.

V. Corrective Action

If it is determined that discrimination or harassment prohibited by this policy has occurred, management shall immediately take action to reasonably ensure that the discrimination or harassment is stopped and does not reoccur.

This Order repeals and replaces Executive Order 1993-4. This Order shall be effective on [date] and shall remain in effect until amended or repealed.

Given under my hand and the Executive Seal of the Office of Governor this ____ day of_____, 2000.

Jim Geringer
Governor

Policy: Executive Order 2000-4
Anti-Discrimination Policy

By signing this document, I hereby acknowledge that I have received a copy of, read and understand the State of Wyoming Anti-Discrimination Policy. I also hereby acknowledge that on the date indicated below I received training on the Anti-Discrimination Policy. I agree to comply with the Anti-Discrimination Policy, and I understand that violation of the policy may result in discipline, up to and including dismissal from employment. I understand that this signed and dated Acknowledgment, or a true and accurate copy thereof, shall be placed in my personnel file.

_____ _____
Signature Date

_____
Name (Please print)

Training Acknowledgment:

Date of Training: _____

_____ _____
Signature Date

ARTS. PARKS. HISTORY.
Wyoming State Parks & Cultural Resources

Information Technology Office
2301 Central Avenue
Cheyenne, WY 82002
(307) 777-6315

Wyoming SPCR Information Technology Section

The following Department Computer Policies, Procedures and Rules must be observed by all employees. Please read and initial each item below:

_____ 1. All computer data, hardware, software, and peripherals are the property of the State of Wyoming and must be protected and used in a proper manner.

_____ 2. Users may not load any software on their PCs without first talking with SPCR IT.

_____ 3. Users may not install any hardware on their PCs without first talking with SPCR IT.

_____ 4. Users may not perform maintenance or repairs on their PCs without discussing the situation with SPCR IT.

_____ 5. No user may repair another user=s PC without talking to SPCR IT.

_____ 6. Any department user can contact SPCR IT staff for assistance unless your supervisor says otherwise.

_____ 7. Department users may not bring computer hardware, software, or peripherals from home to install or load on their office PC. If they do, the item automatically becomes the property of the State.

_____ 8. Users are responsible for maintaining the highest security standards for their PCs and the Network. Users WILL NOT share their passwords with another user.

Infractions to these policies/procedures/rules will result in an immediate lockout of the user=s login rights as well as denial of access to data and the network server.

Failure to abide by these SPCR PC policies and procedures may lead to the following:

1. User and user=s supervisor will be notified of infraction(s) and counseled on correct choices.

2. User will receive a Memorandum of Understanding outlining the department=s PC Policies and Procedures.

3. Further infractions, SPCR IT will notify the Human Resources section and the manager or supervisor of the employee for help in correcting the problem(s). SPCR IT may recommend to HR the user be denied further access to PCs and servers until SPCR IT meets with the supervisor and user to discuss the problem(s).

4. Any user who steals, sabotages, purposely or accidently breaks a PC or other components doing unauthorized installs or repairs, and who carelessly opens their PC to viruses that result in the disabling of the PC will be referred to the Attorney General=s Office for discipline.

_____ _____
Employee/User Date

3400-P010: Email Management

I. PURPOSE

To promote consistent and efficient use of IT resources and improve data sharing among agencies by the establishment of an enterprise electronic mail system.

II. SCOPE

This policy applies to all Executive Branch agencies, boards and commissions, (collectively referred to as agencies) and all other entities that access the State of Wyoming enterprise email system.

POLICY

A. General
   1. All Executive Branch agencies, boards, and commissions will utilize the enterprise Wyoming email system.
   2. Enterprise email system, for purpose of this policy, shall mean all information processing equipment and software employed for electronic transfer of information through mail protocols such as SMTP or IMAP including, but not limited to; computers, servers, wireless devices, facilities for Internet/Intranet access, storage media, software and all data associated with this system.
   3. Ownership - The State of Wyoming owns the electronic mail data and reserves the right to specify and control its use. All accounts, and messages sent or received or stored on backup media are the property of the State of Wyoming. In the event of any employee termination or interagency transfer, the employee's email account may be deleted, redirected to the employee's successor or appropriate management, or transferred to the employee's new agency as determined by the originating agency.
   4. Official Records - Employees should be aware that documents created in, sent by, or attached to electronic mail may constitute official records of the State of Wyoming. To the extent that email constitutes a "record" for records management purposes, there may be State statutes or other policies affecting its use and maintenance.

B. Usage Rules
   1. Authorized Access – Agencies may grant their employees access to the enterprise email system to carry out their assigned duties. Access for non-state employees shall be granted only with approval of the agency director or their designee. Access to the email system may be denied by the agency at any time if it is determined that access is no longer needed or there has been a violation of policy or other abuse of the system. In emergency situations a designated email administrator may temporarily suspend an account and will notify the affected agency.

3400-P010: Email Management

2. Unacceptable Use - The following uses are unacceptable and prohibited. The list is not exhaustive, but attempts to supply a scope of what activities are unacceptable.
    a. Illegal Activities – Any illegal or wrongful conduct is prohibited. Any information or knowledge regarding illegal actions will be provided to the Attorney General, Division of Criminal Investigation or other appropriate law enforcement agency.
        i. Intellectual Property Infringement – Inclusion of copyrighted material in email that would violate copyright laws is prohibited.
        ii. Discrimination and Harassment - The use of the email system to transmit data which is disparaging or harassing to individuals or groups will not be tolerated. This includes, but is not limited to writings, drawings, jokes or any other form of data that is degrading or harassing to others based on an individual's race, religion, color, sex, national origin, age or disability.
        iii. Insensitive or Profane language – Users must not send messages containing offensive, derogatory, profane or abusive language.
        iv. Objectionable Material – Users must not use the system to distribute pornography, malicious code or illegal software.
        v. Interference with system operation - Any use that seriously and unduly affects system functionality is prohibited. This includes, but is not limited to intentional misuse of group addresses, forwarding chain letters, sending SPAM messages, email bombs, initiating denial of service attacks or other forms of cyber terrorism.
    b. Use of other accounts - The use of another user's account or intentionally falsifying an identity to send or receive communications (identity theft) is prohibited. At the discretion of the agency, proxy rights may be granted by one user to another.
    c. Personal Gain – The system may not be used for personal commercial ventures or other personal gain.
    d. Religious or Political Use – Using the system for promotion of religious or political causes or endorsement of candidates is prohibited.
3. Personal Use - The State of Wyoming's email system is to be used primarily for legitimate state business purposes. Incidental personal use is not prohibited, but such use must not unreasonably affect the employee's work performance or the conduct of State of Wyoming business activities, and must not compromise system security.
4. Email Signature - Users shall use email signature blocks to provide contact information to the recipient, as a part of all messages with a destination outside of this system. Email signature blocks will be in the standard format noted in the email standards document. (see 3400-S010 Email Management Standard)
5. Disclaimer Statement – There will be a State disclaimer appended to all sent email. At the agency's discretion additional disclaimers can be added, (see 3400-S010 Email Management Standard)

3400-P010: Email Management

C. Managing Email
   1. Monitoring and Access - The State of Wyoming reserves the right to inspect all email related data at any time as authorized by statute or policy.
   2. Data Backup and Recovery, Email Message size, Attachments, and Archive – Each of these are subject to the terms of the agreement with the email provider.
   3. Naming Conventions - To provide consistency and ease of use, standard naming conventions will be required, primarily for address book related data. This will be done in accordance with the naming conventions noted in the email standards document. In addition to naming conventions, aliases can be used provided the alias does not conflict with other previous existing account names or aliases. (see 3400-S010 Email Management Standard)
   4. Retention of Public Records – Email content created or received in the course of conducting State of Wyoming business will be retained and maintained in an alternative format as prescribed by state and agency records retention schedules.
   5. Litigation and Discovery – Email which has been identified in any court or regulatory proceedings as having a high likelihood of imminent litigation shall remain available for discovery until the legal hold has been removed. In all situations where this section applies, an email system administrator must be notified immediately.

CIO Approved Date: 2/17/12

EXECUTIVE BRANCH E-MAIL POLICY ACKNOWLEDGMENT

By my signature and dating of this document below, I hereby certify I have had an opportunity to read the State of Wyoming E-mail Policy as stated in the 3400-P010: Email Management Policy of the Wyoming Enterprise Technology Department. I further hereby submit I understand and will abide with those requirements as stated in the State of Wyoming E-mail Policy with respect to my employment at the State of Wyoming. Moreover, I hereby understand the original of this document signed and dated by me shall be kept in my personnel file and any violation of the State of Wyoming E-mail Policy by me may result in disciplinary actions being taken against me, up to and including my dismissal from employment, as allowed pursuant to the State of Wyoming Personnel Rules.

_____
Signature

_____
Date

10/2013

1200-P143: Internet Acceptable Use Policy

I. PURPOSE

To establish a policy for use of the Internet and the State's electronic communication systems for state agencies and their employees. The Internet Acceptable Use Policy is designed to help employees understand management's expectations for granting employees access to the Internet and/or electronic communication systems and to help employees to use State resources wisely. While a direct connection to the Internet offers a variety of benefits to the State of Wyoming, it can also expose the State to some significant risks to its data and systems if appropriate security measures are not employed. Excessive, unnecessary Internet usage causes network and server congestion. It slows down other users, takes time away from work, consumes supplies, and ties up printers and other shared resources. Unlawful Internet usage may expose the State of Wyoming and/or the individual user to significant legal liabilities.

II. SCOPE

This policy applies to all executive branch agencies, boards, and commissions (collectively referred to as "agencies").

III. POLICY

Access to the Internet and the State's electronic communication systems is not a right of any individual, but is a revocable privilege subject to existing state rules governing the use of State of Wyoming equipment and services. Management reserves the right to revoke the privilege at anytime.

1. General Provisions.

   a. Business Use: Agency-provided computer systems that allow access to the Internet and electronic communication systems are the property of the State and are provided to facilitate the effective and efficient conduct of State business. Users are permitted access to the Internet and electronic communication systems to assist in the performance of their jobs.

   b. Personal Use: Personal use means use that is not job-related. In general, incidental and occasional personal use of the State's Internet access or electronic communication systems is permitted; however, personal use is prohibited if it:

      i. interferes with the user's productivity or work performance, or with any other employee's productivity or work performance;

      ii. adversely affects the efficient operation of the computer system or network;

iii. violates any provision of this policy, any supplemental policy adopted by the agency supplying the Internet or electronic communication systems, or any other policy, regulation, law or guideline as set forth by local, State or Federal law.

c. No Expectation of Privacy: No user shall have any expectation of privacy in any message, file, image or data created, sent, retrieved or received by use of the State's equipment and/or systems. Agencies have a right to monitor any and all aspects of their computer systems including, but not limited to, sites, instant messaging systems, chat groups, or news groups visited by agency users, material downloaded or uploaded by agency users, and e-mail sent or received by agency users. Such monitoring may occur at any time, without notice, and without the user's permission, to the extent allowed by law. In addition, electronic records may be subject to the Freedom of Information Act (FOIA) and/or the Wyoming Public Records Act and, therefore, available for public distribution.

d. Prohibited Activity: Certain activities are prohibited when using the Internet or electronic communications; these include, but are not limited to:

i. Accessing, downloading, printing, or storing information with sexually explicit content;

ii. Downloading or transmitting fraudulent, threatening, obscene, intimidating, defamatory, harassing, discriminatory, or otherwise unlawful messages or images;

iii. Installing or downloading computer software, programs, or executable files contrary to policy;

iv. Uploading or downloading copyrighted materials or proprietary agency information contrary to policy;

v. Permitting a non-employee to use state resources except in situations where those state resources are intended for public use;

vi. Any other activities designated as prohibited by the Agency.

2. User Responsibilities.

a. The conduct of computer users who access the Internet or send e-mail containing an agency's domain address (i.e., *@state.wy.us, @agency.state.wy.us, or @agency.wyo.gov)* may be perceived as reflecting on the character and professionalism of the agency and the State of Wyoming. When engaging in such conduct, whether for personal or official purposes, employees are expected to do so in a

responsible and professional manner. Users employing the State's Internet or electronic communication systems for personal use must present their communications in such a way as to be clear that the communication is personal and is not a communication of the agency.

b. Access privileges to State information and IT resources come with user responsibilities. Acceptance of these responsibilities is a condition of employment and is required for initial and continuing access to State information and IT resources. Refer to Security Policy 142 "User Responsibilities" for details.

3. Agency Responsibilities.

a. Agencies may develop a written policy, consistent with this policy which supplements or clarifies specific issues for the agency. With regard to use of the Internet and electronic communications, agencies are responsible for:

i. Communicating this policy and agency policy, if appropriate, to current users and to new users before granting them access to agencies' Internet or electronic communication systems;

ii. Retaining electronic records in accordance with the retention requirement of the State of Wyoming;

iii. Requiring and retaining acknowledgement statements, signed by each user, acknowledging they have received and read a copy of this policy and any applicable agency policy before access to the system will be granted.

CIO Approved Date: 1/2/2009

EXECUTIVE BRANCH INTERNET USE POLICY ACKNOWLEDGMENT

By my signature and dating of this document below, I hereby certify I have had an opportunity to read the State of Wyoming 1200-P143: Internet Acceptable Use Policy of the Wyoming Enterprise Technology Department. I further hereby submit I understand and will abide with those requirements as stated in the State of Wyoming Internet Acceptable Use Policy with respect to my employment at the State of Wyoming. Moreover, I hereby understand the original of this document signed and dated by me shall be kept in my personnel file and any violation of the State of Wyoming Internet Acceptable Use Policy by me may result in disciplinary actions being taken against me, up to and including my dismissal from employment, as allowed pursuant to the State of Wyoming Personnel Rules.

_____

Signature

_____

Date

2/2007

Department of State Parks and Cultural Resources
Reference Policy

Negative job references have become an expanding source of concern. The safest approach is to have all requests for information on current or former employees channeled through the Human Resource section. No information will be released without a signed waiver from the individual in question. Generally, references will be limited to title and employment dates. Any exceptions will be reviewed and approved by the Wyoming Attorney General's Office.

If you are asked to serve as a personal reference it is advised you do so outside your official capacity as a state employee of the Department of Parks and Cultural Resources.

My signature indicates my awareness and understanding of the Department of State Parks & Cultural Resources Reference Policy.

_____
Print Name

_____ _____
Signature Date

REGISTRATION FORM

WRS Retirement Number ⬇

Completed form must be received within 10 business days of employment and allow 5 business days for processing.

SSN: _____

Legal Name *(as shown on your social security card)*: _____
(Last Name) (First Name) (Middle Initial)

Address: _____
(Mailing Address) (City) (State) (Zip)

Sex: M ____ F ____ Date of Birth: _____ Telephone Number: (____) _____

Email address: _____

BENEFICIARY DESIGNATION - Please complete the Beneficiary Designation on Page 2.

PREVIOUS WYOMING RETIREMENT SYSTEM CONTRIBUTION INFORMATION

Were contributions previously made to the Retirement System? ☐ Yes ☐ No If yes, provide information below.

Previously employed by:

1) Agency Name: _____ Date from _____ to _____
2) Agency Name: _____ Date from _____ to _____
3) Agency Name: _____ Date from _____ to _____

Contributions were: ☐ Withdrawn ☐ Left on Deposit, and made under the name(s) of _____

➤**If you are drawing a monthly benefit from the same Plan for which you are registering, please complete form WRS-9**➤

My employer and I have discussed my job duties and have determined I am eligible to participate in the Retirement Plan marked below. I understand that if I am placed in the wrong plan, my benefit will be affected at retirement.

X _____ _____
Signature of Applicant Date

Must be completed by Employer

Employer Name _____ Employee's Job Title _____

WRS/Agy Number _____ Monthly Salary or Hourly Rate $_____

Employment Date _____ IF CONTRIBUTIONS DO NOT START AT THE TIME OF EMPLOYMENT, PLEASE INDICATE DATE CONTRIBUTIONS WILL BEGIN AND EXPLAIN THE DISCREPANCY _____

PLEASE MARK WHICH RETIREMENT PLAN AND INDICATE FULL-TIME OR PART-TIME:
(Participating in the wrong Retirement Plan will affect your employee's benefit at retirement)

- ❒ Regular Retirement Plan
- ❒ State AWEC
- ❒ Judicial Plan
- ❒ Law Enforcement Plan *(must be POST certified AND meet the definition of a law enforcement officer as defined by W.S. 9-3-402)*
- ❒ Paid Fire Plan
- ❒ Warden/Patrol/DCI/Capitol Police Plan
- ❒ Guard Firefighter

- ❒ Full-Time
- ❒ Regular Part-Time *(as defined by your agency and approved by WRS)*

X _____ _____
Authorized Employer Signature Date

Phone Number: _____

WRS Office Use Only

Tier 1 ❒ Tier 2 ❒

Entered: _____

Verified: _____

Beneficiary Information

Primary Beneficiary

Sole Beneficiary:

You may designate one individual as sole beneficiary. When a sole beneficiary is designated, payment options depend upon the member's length of credited service.

Multiple Beneficiaries:

You may designate more than one beneficiary. When multiple beneficiaries are designated, monthly retirement benefits ARE NOT an option and payments will be made in a lump-sum only. When multiple beneficiaries are designated, the lump-sum payment will be made to the beneficiaries in equal shares unless otherwise specified in writing to the Wyoming Retirement System.

Alternate/Contingent Beneficiaries

You may designate one or more alternate/contingent beneficiaries. Should your primary beneficiary(ies) not survive you, payments will be made to your alternate beneficiary(ies) as specified.

If your beneficiaries are deceased at the time of your death or you do not designate a beneficiary, a lump-sum payment will be made to your estate. If you choose to list your estate or trust as beneficiary, a monthly retirement benefit is not available.

(If you are married and a member of the Law Enforcement Plan, Warden/Patrol/DCI Plan, or Paid Firemen's Pension Fund, your spouse MUST be your primary beneficiary.)

Primary Beneficiary

Name _____ SSN _____ Relationship _____ DOB_____ %_____

Name _____ SSN _____ Relationship _____ DOB_____ %_____

Name _____ SSN _____ Relationship _____ DOB_____ %_____

Alternate/Contingent

Name _____ SSN _____ Relationship _____ DOB_____ %_____

Name _____ SSN _____ Relationship _____ DOB_____ %_____

Name _____ SSN _____ Relationship _____ DOB_____ %_____

Important Notice:
Benefits provided under the pension plans administered by the Wyoming Retirement System represent merely one aspect of a member's retirement financial planning and should not be expected to replace one hundred percent (100%) of the member's pre-retirement income. Cost-of-living and other benefit increases are not incorporated into a member's benefit, emphasizing the importance for members to build additional resources for retirement income, such as personal savings. Additionally, pursuant to Wyo. Stat. 9-3-428, although members have a nonforfeitable interest in their accrued and funded benefits, the State of Wyoming is statutorily obligated only for the contributions required by the Wyoming Retirement Act.

WRS Office Use Only

Entered: _____

Verified: _____

_____ _____

Applicant's Name *(please print)* Social Security Number

X _____ _____

Signature of Applicant Date

Participant Enrollment
Governmental 457(b) Plan

Wyoming Retirement System 457 Deferred Compensation Plan

State Government Employee 93001-01 ❑
Other Government Employee 93001-02 ❑

Section 1 - Participant Information

Last Name | First Name | MI

Social Security Number

Mailing Address

E-Mail Address

City | State | Zip Code

❑ Married ❑ Unmarried ❑ Female ❑ Male

( ) Home Phone ( ) Work Phone

Mo Day Year — Date of Birth

Mo Day Year — Date of Hire

Annual Income

Do you have a retirement savings account with a previous employer or an IRA? ❑ Yes or ❑ No

Section 2 - Payroll Information

❑ I elect to contribute $_____ ($20.00 - $18,500.00) per pay period of my compensation as before-tax contributions to the Governmental 457(b) Deferred Compensation Plan until such time as I revoke or amend my election.

❑ I elect to contribute $_____ ($20.00 - $18,500.00) per pay period of my compensation after-tax as a designated Roth contribution to the Governmental 457(b) Deferred Compensation Plan until such time as I revoke or amend my election.

Note: You must contribute a minimum of $20.00 per month and the total of your before-tax and Roth deferrals cannot exceed $18,500.00. If I am 50 years of age or older and I am eligible for a catch-up contribution, I understand I may exceed this total.

Payroll Effective Date: Mo Day Year

Employer Name | Department Number | Division Number

Section 3 - Quick Enrollment **(If you complete this section, do not complete Sections 4 or 5.)**

❑ By checking this box, I understand that my contributions will be allocated to the age appropriate target date fund without additional action by me. I acknowledge that information about Plan investment options, including prospectuses, disclosure documents and Fund Data sheets are available to me through my Plan Administrator or Plan Web site. I understand the risks of investing and that all payments and account values may not be guaranteed and may fluctuate in value. *Until such time as you choose investment options for your Plan account, your contributions will be invested in the fund within this portfolio that most closely corresponds to certain factors in your profile. For more information, please contact your WRS Representative.*

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I understand that I have the right to direct the investment of my account and that I can change my investment allocation from the target date fund at any time by logging on to my account at www.wrsdcp.com or by calling the Voice Response System at 1-800-701-8255. *A personal identification number (PIN) that gives you access to your account via the Web or phone will be mailed to you soon after your application processed. You are responsible for keeping the assigned PIN confidential. Please contact us if you suspect unauthorized use.*

Last Name	First Name	M.I.	Social Security Number	93001-01/-02 Number

TARGET DATE INVESTMENT NAME	CODE	BIRTH YEAR	TARGET DATE INVESTMENT NAME	CODE	BIRTH YEAR
LifePath Index Retirement Fund Q	BRLIRQ	Up to 1952	LifePath Index 2040 Fund Q	BRL40Q	1973 to 1977
LifePath Index 2020 Fund Q	BRL20Q	1953 to 1957	LifePath Index 2045 Fund Q	BRL45Q	1978 to 1982
LifePath Index 2025 Fund Q	BRL25Q	1958 to 1962	LifePath Index 2050 Fund Q	BRL50Q	1983 to 1987
LifePath Index 2030 Fund Q	BRL30Q	1963 to 1967	LifePath Index 2055 Fund Q	BRL55Q	1988 to 1992
LifePath Index 2035 Fund Q	BRL35Q	1968 to 1972	LifePath Index 2060 Fund Q	BRL60Q	1993 and on

Section 4 - Investment Option Information (If you complete this section, do not complete Sections 3 or 5.) - Applies to all contributions.

Select My Own Investment Options:

❑ By checking this box, I elect to direct my own investments either with "Pre-Mixed Funds" or "Mix-Your-Own Funds" offered in the Plan. By electing "Select My Own Investment Options," I agree to, understand and acknowledge the following:

1. I had the opportunity to have an investment expert, Advised Assets Group, LLC ("AAG"), make investment decisions on my behalf and I chose not to accept this option.
2. I am required to direct all the investments of my accounts (current balance, future contributions and rollover monies) in this Plan by completing the investment election in the Investment Option Information section.
3. I take full responsibility for my own investment elections.
4. I have received and reviewed the information in my enrollment kit about my investment choices and have had an opportunity to freely choose how my accounts are invested. I further understand and agree that my employer and other Plan fiduciaries will not be liable for the results of my personal investment decisions.

Please refer to your communication materials for investment option designations. Please refer to Participant Agreement for information regarding transfer restrictions.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I will refer to the fund's prospectus and/or disclosure document for more information.

INVESTMENT OPTION NAME PRE-MIXED PORTFOLIOS	INVESTMENT OPTION CODE (Internal Use Only)	
LifePath Index Retirement Fund Q	BRLIRQ	_____%
LifePath Index 2020 Fund Q	BRL20Q	_____%
LifePath Index 2025 Fund Q	BRL25Q	_____%
LifePath Index 2030 Fund Q	BRL30Q	_____%
LifePath Index 2035 Fund Q	BRL35Q	_____%
LifePath Index 2040 Fund Q	BRL40Q	_____%
LifePath Index 2045 Fund Q	BRL45Q	_____%
LifePath Index 2050 Fund Q	BRL50Q	_____%
LifePath Index 2055 Fund Q	BRL55Q	_____%
LifePath Index 2060 Fund Q	BRL60Q	_____%
MIX-YOUR-OWN FUNDS		
WRS Capital Preservation Fund	WYOSVF	_____%
WRS Fixed Income Fund	WRSINC	_____%
WRS Real Assets Fund	WRSRAS	_____%
WRS Large Cap U.S. Equity Fund	WRSLRG	_____%
WRS International Equity Fund	WRSITL	_____%
WRS Small/Mid Cap U.S. Equity Fund	WRSSMD	_____%
MUST INDICATE WHOLE PERCENTAGES		**= 100%**

The Pre-Mixed Portfolios offer you a fast and easy way to adopt an overall investment solution that seeks to maximize assets for retirement or other purposes, based on an investor's investment time horizon. Just determine the year you plan to retire or begin withdrawing money from your account, then select the corresponding Pre-Mixed Portfolio. Each well diversified portfolio contains a blend of investments. These portfolios are based on asset allocation strategies that have been developed, tested and employed by Black Rock Investments.

The Mix-Your-Own Funds allow you to review and select your investments, and manage your account on an ongoing basis. With Mix-Your-Own Funds, you have the opportunity to create a custom asset allocation. These funds represent a range of asset classes and investment management styles.

Participants choosing an Investment Portfolio strategy in Section 4 can use option Free Investment Guidance of for a $25 annual fee, Investment Advice provided by Advised Assets Group, LLC. Download a Reality Advisory Services flyer that contains information detailing these services and how to use them at www.wrsdcp.com.

NOTE: If you complete more than one of the following Sections, 3, 4 or 5, the form will be rejected.

Section 5 - Managed Accounts Service (If you complete this section, do not complete Sections 3 or 4.)

❑ By checking this box, I elect to have my account professionally managed by Advised Assets Group, LLC ("AAG") ("Managed Account") until such time as I revoke or amend this election. I understand that Managed Account is a completely optional, fee based service and my account will be charged a maximum of .45% of the account balance on a quarterly basis for Managed Accounts. Further, I understand, WRS also offers "pre-mixed portfolios" that I may select based on my target retirement date or the option to mix my own funds (see Section 4).

By electing Managed Accounts, I agree to the following:

Managed Account Service Information

The Managed Accounts Service provided by Advised Assets Group, LLC ("AAG") will automatically direct your investment election for future contributions and will rebalance your account quarterly, if necessary. This election will be effective the day of receipt if received in good order by Service Provider prior to New York Stock Exchange market close. Any request received after New York Stock Exchange market close will be considered received the next business day. By electing the Managed Accounts Service, I agree to the fees associated with this service and understand the fee will be deducted from my account on a quarterly basis in accordance with the attached Managed Accounts Agreement. If you prefer to make your own investment decisions and not participate in this service, simply select the Select My Own Investment Options box in Section 4 and enter your investment instructions in the Investment Option Information section.

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document or applicable state law.

You may only designate one primary and one contingent beneficiary on this form. However, the number of primary or contingent beneficiaries you name is not limited. If you wish to designate more than one primary and/or contingent beneficiary, do not complete the section below. Instead, complete and forward the Beneficiary Designation form.

Primary Beneficiary

100.00%

% of Account Balance | Primary Beneficiary Name | Date of Birth

( )

Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

Contingent Beneficiary

100.00%

% of Account Balance | Contingent Beneficiary Name | Date of Birth

( )

Phone Number *(Optional)*

Relationship *(Required - If Relationship is not provided, request will be rejected and sent back for clarification.)*

❑ Spouse ❑ Child ❑ Parent ❑ Grandchild ❑ Sibling ❑ My Estate ❑ A Trust ❑ Other ❑ Domestic Partner

Participation Agreement

Withdrawal Restrictions - I understand that the Internal Revenue Code (the "Code") and/or my employer's Plan Document may impose restrictions on transfers and/or distributions. I understand that I must contact the Plan Administrator/Trustee to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

Investment Options - If I elect to direct my own investments, I understand that by signing and submitting this Participant Enrollment form for processing, I am requesting to have investment options established under the Plan as specified in the Investment Option Information section. I understand and agree that this account is subject to the terms of the Plan Document. I understand and acknowledge that all payments and account values, when based on the experience of the investment options, may not be guaranteed and may fluctuate, and, upon redemption, shares may be worth more or less than their original cost. I acknowledge that investment option information, including prospectuses, disclosure documents and Fund Profile sheets, have been made available to me and I understand the risks of investing.

I understand if I elect to have my account managed by Advised Assets Group, LLC ("AAG"), that my entire account, including any transfers or rollovers, will be professionally managed and I have not completed the Investment Option Information section. Dollar cost averaging and asset allocation are not available if my account is professionally managed. I understand that the applicable fees will be deducted from my account. In order to enroll in the Managed Accounts Service, I understand that I must provide my Social Security number, date of birth, gender, marital status and annual income. If any of this information is not provided, I understand that I will not be enrolled in the Managed Accounts Service.

Last Name	First Name	M.I.	Social Security Number	93001-01/-02 Number

Compliance With Plan Document and/or the Code - I agree that my employer or Plan Administrator/Trustee may take any action that may be necessary to ensure that my participation in the Plan is in compliance with any applicable requirement of the Plan Document and/or the Code. I understand that the maximum annual limit on contributions is determined under the Plan Document and/or the Code. I understand that it is my responsibility to monitor my total annual contributions to ensure that I do not exceed the amount permitted. If I exceed the contribution limit, I assume sole liability for any tax, penalty, or costs that may be incurred.

Incomplete Forms - I understand that in the event my Participant Enrollment form is incomplete or is not received by Service Provider at the address below prior to the receipt of any deposits, I specifically consent to Service Provider retaining all monies received and allocating them to the default investment option selected by the Plan. If no default investment option is selected, funds will be returned to the payor as required by law. Once an account has been established on my behalf, I understand that I must call the Voice Response System or access the Web site in order to transfer monies from the default investment option. Also, I understand all contributions received after an account is established on my behalf will be applied to the investment options I have most recently selected.

Account Corrections - I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days of the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Provider of an error after this 90 days, the correction will only be processed from the date of notification forward and not on a retroactive basis.

Managed Accounts Service Fee - If you elect the Managed Accounts Service, a quarterly fee will be assessed. If you wish to opt-out in the future please call an Advised Assets Group, LLC ("AAG") Representative at your Plan's the Voice Response System number.

Signature(s) and Consent

Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form including the terms of the Managed Accounts Agreement. I understand that Service Provider is required to comply with the regulations and requirements of the Office of Foreign Assets Control, Department of the Treasury ("OFAC"). As a result, Service Provider cannot conduct business with persons in a blocked country or any person designated by OFAC as a specially designated national or blocked person. For more information, please access the OFAC Web site at:
http://www.treasury.gov/about/organizational-structure/offices/Pages/Office-of-Foreign-Assets-Control.aspx.

Participant Signature **Date**

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Participant forward to Deferred Compensation Plan

Authorized Plan Administrator/Trustee Approval

Authorized Plan Administrator/Trustee Signature **Date**

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

Print Full Name

Plan Administrator forward to Service Provider at:
Wyoming Retirement System
6101 Yellowstone Road, Suite 500
Cheyenne, WY 82002
Phone #: 1-800-989-9324
Fax #: 1-307-777-3621
Web site: www.wrsdcp.com

ADVISED ASSETS GROUP, LLC
ADVISORY SERVICES AGREEMENT

Please read the following terms and conditions carefully before using or enrolling in any of the services described below. Your use of any service will signify your consent to be bound by the terms and conditions set forth in this Agreement.

ABOUT US

Advised Assets Group, LLC ("AAG") is a federally registered investment adviser and wholly owned subsidiary of Great-West Life & Annuity Insurance Company ("Great-West"). AAG offers its services to retirement account recordkeepers for use by plan participants or to owners of an Empower Retirement Individual Retirement Account ("IRA"). Through these arrangements, AAG provides guidance, advisory, and management solutions to plan participants and IRA account holders.

FEES FOR THE SERVICE

AAG offers three levels of service: Online Investment Guidance, Online Investment Advice and Managed Account. Fees for each service are shown below. The chart below reflects the applicable billing period and annual fee amount.

Online Investment Guidance	**Quarterly Fee**	**Annual Fee**
	No Fee	No Fee

Online Investment Advice	**Quarterly Fee**	**Annual Fee**
	$6.25	$25.00

Managed Account		
Participant Account Balance	**Quarterly Fee**	**Annual Fee**
≤ $100,000.00	0.1125%	0.45%
Next $150,000.00	0.0875%	0.35%
Next $150,000.00	0.0625%	0.25%
≥ $400,000.01	0.0375%	0.15%

For example, if your account balance subject to the Managed Account service is $50,000.00, the maximum annual fee is 0.45% of the account balance. If your account balance subject to the Managed Account service is $500,000.00, the first $100,000.00 will be subject to a maximum annual fee of 0.45% (quarterly 0.1125%), the next $150,000.00 will be subject to a maximum annual fee of 0.35% (quarterly 0.0875%), the next $150,000.00 will be subject to a maximum annual fee of 0.25% (quarterly 0.0625%), and any amounts over $400,000.00 will be subject to a maximum annual fee of 0.15% (quarterly 0.0375%). For example, the maximum quarterly fee for an account balance less than $100,000.00 (subject to maximum annual fee of 0.45%) would be 0.1125% quarterly, as demonstrated above.

The fees for Online Investment Advice and the Managed Account service will generally be debited from your account based on AAG's Form ADV Brochure and the terms of service and billing period agreed upon by your plan sponsor; however, if you cancel participation in the Managed Account service, the fee will be based on your participation in the service through the date of cancellation. Use of Online Investment Advice at any time during a billing period will result in your account being debited the billing period fee. If your Plan terminates its agreement with AAG or with its recordkeeper, the fee will be debited based on your participation in the service through the date of such termination. The fee you are charged depends on the Plan you participate in, and in certain instances, the fees charged may actually be lower than the fee depicted.

IMPORTANT FOR RETIREMENT PLAN PARTICIPANTS

Your plan sponsor or recordkeeper may have negotiated lower fees or different billing periods. Your Managed Account fee may include an additional solicitation fee in an amount up to 0.25% annually of the total assets under management. If your plan sponsor has engaged a solicitor, your Managed Account fee will be higher than if a solicitor were not engaged. Please review AAG's Form ADV Brochure and contact your plan sponsor or plan administrator to confirm your fees for AAG services and the applicable billing cycle.

Retirement plan participants may also receive the Managed Account service for a free look period of 90 days from the date of your initial enrollment, after which the appropriate fee listed above will be assessed to your account. If you do not opt-out by the end of the free look period, you will be assessed a fee for the entire billing period as described in the section entitled, "Fees for the Service." Please contact your plan sponsor to determine if the free look period applies to your plan. You may contact AAG for the date of your Managed Account enrollment.

Your acceptance of the terms and conditions of this Agreement constitutes your authorization for AAG to deduct the billing period fee. The fees are subject to change. AAG reserves the right to offer discounted fees or other promotional pricing.

DESCRIPTION OF SERVICES

AAG offers the following investment advisory services: Online Investment Guidance, Online Investment Advice, and Managed Account through Advisory Services to retirement plan participants and to IRA Account holders. Retirement plan participants may receive all or some of the services listed below as determined by the plan sponsor. If you are enrolled in multiple accounts with your employer, you

must select the level of Advisory Service for each account. Please contact AAG for further details as to whether this applies to your account(s).

Online Investment Guidance: The Online Investment Guidance service is geared toward users who wish to manage their own retirement accounts. Users are provided access to online guidance tools.

Online Investment Advice: Online Investment Advice service is geared toward users who wish to manage their own retirement plans while taking advantage of online guidance and investment advice. You are provided online guidance and investment advice for a personalized recommended investment portfolio. The recommended investment portfolio is based on information drawn from your account profile and from the investment options available to you. You may then implement the recommended investment portfolio and manage your retirement account online. AAG does not provide advice for, or recommend allocations of, individual stocks (including employer stock), self-directed brokerage accounts, guaranteed certificate funds, or employer-directed monies.

Managed Account: The Managed Account service is geared toward users who wish to have a financial expert select among the available investment options and manage their retirement accounts for them. You will receive a personalized investment portfolio that reflects your investment options and your retirement timeframe, life stages and overall financial picture, including assets held outside your account (if you elect to provide this information), which may be taken into consideration when determining the allocation of assets in your account (AAG will not provide advice for, recommend allocations of, or manage your outside accounts). Under the Managed Account service, AAG has discretionary authority over allocating your assets among the core investment options without your prior approval of each transaction. AAG is not responsible for either the selection or maintenance of the investment options available within your retirement account or IRA. If available in your account, AAG will not provide advice for, or recommend allocations of, individual stocks (including employer stock), self-directed brokerage accounts, guaranteed certificate funds, or employer-directed monies. Your balances in any of these investment options or vehicles may be liquidated, subject to your plan's and/or investment provider's restrictions.

Managed Account assets in the core investment options will be automatically monitored, rebalanced and reallocated periodically (approximately quarterly) by AAG, based on data resulting from the methodologies and software employed by the Independent Financial Expert, currently Morningstar Investment Management LLC ("Morningstar Investment Management"), to respond to market performance and to ensure optimal account performance over time. You will receive an account update and forecast statement annually and can update your personal information at any time by contacting AAG.

To determine which services are available to you, please refer to the communication materials provided by AAG or ask your plan sponsor.

INFORMATION FOR PARTICIPATION IN THE SERVICE

Information Gathered to Provide the Service: You must provide all data that is necessary for AAG to perform its duties under this Agreement, including but not limited to: your date of birth, income, gender, and state of residence, which AAG may rely upon in providing the services to you. For each service described above, if the data supplied by you or your Plan Sponsor, if applicable, does not meet the methodology requirements, we will attempt to contact you for updated information. If this is not completed, your enrollment in the service may not be completed or may be terminated.

If you participate in the Managed Account service, you will receive a Welcome Kit shortly after enrollment. Please review the Welcome Kit carefully and contact AAG to update or correct any incorrect personal information. You will also receive an Annual Kit each year, providing you with a detailed analysis of your account. Your Annual Kit will also confirm your personal data which is used to provide you with personalized account management. You may also provide additional information, at any time, regarding your retirement age, desired retirement income replacement, social security start date, other income and expenses, spousal and dependent information. The savings rate provided by your retirement plan recordkeeper may not include profit sharing, pensions or employer matches to your retirement plan(s). Please contact AAG to verify these amounts.

It is important that you update your personal data with AAG on a regular basis in order to ensure that your account management is suited to your needs and goals.

ADDITIONAL INFORMATION FOR USERS OF THE SERVICE

Methodology: The Advisory Services methodology is powered by Morningstar Investment Management. Morningstar Investment Management first builds stable, consistent asset allocation models at various risk levels. Based on Monte Carlo simulations of the user's resources, liabilities, and human capital, an appropriate asset level portfolio is selected and a savings rate and retirement age are determined that best suits each user's situation. The asset class level model portfolios are revisited annually. Investment options from the account's menu are then selected to implement each asset-level model portfolio. These investment options are monitored and rebalanced quarterly.

IMPORTANT: The projections or other information generated by the advisory service tool regarding the likelihood of various investment outcomes are hypothetical in nature, do not reflect actual investment results and are not guarantees of future results. Results may vary with each use and over time.

Additional Fees May Apply: Certain investment options in your account may charge a redemption fee or impose restrictions for market timing. Such restrictions or redemption fees vary in amount and application from investment option to investment option. It is possible that transactions initiated by AAG under Online Investment Advice or the Managed Account service may result in the imposition of a redemption fee or marketing timing base restriction on one or more investment options available to you. Any redemption fees will be deducted from your account balance.

Assets Managed: If you elect the Managed Account service, your eligible account balance will be allocated to the Managed Account service. You may not invest in other core investment options while also participating in the Managed Account service. Once enrolled in the Managed Account service, you will no longer be able to make investment allocation changes to your account online, via paper, or through your AAG's existing toll-free customer service number. This includes functionality for fund-to-fund transfers, change fund allocations, or utilization of dollar cost averaging and/or rebalancer. Once enrolled, you retain full inquiry access to your account. You may also change contributions, take distributions and provide other updates to your personal information. Full access will be restored to your account within one business day after you cancel participation in the Managed Account service.

Cancellation: You may cancel participation in the Managed Account service at any time by completing the cancellation form available online or by calling AAG. Once you have opted-out of the Managed Account service, you are responsible for managing your own account. In addition, your allocations and account balance (if applicable) will have already been established according to the Managed Account allocations. You will need to initiate your own allocation changes and/or transfers if you wish to change your investment allocations from the Managed Account allocations.

Initial Allocation for IRA Account Holders: Upon receipt of your initial deposit or rollover into your IRA, your funds will be allocated to the default investment option specified in your custodial agreement. AAG will re-allocate your funds to your asset allocation portfolio within 5 business days of receiving your initial deposit.

Important note for accounts with a Guaranteed Lifetime Withdrawal Benefit: If you are within ten years of your targeted retirement date and enroll in the Online Investment Advice or Managed Account services, AAG may recommend or allocate a percentage of your account (which may be up to 70% of total known retirement assets, as deemed appropriate by the Advisory Services methodology) to what is commonly known as a guaranteed lifetime withdrawal benefit ("GLWB"). Allocations to the GLWB will result in an additional fee that is in addition to the fees noted within the fee table above. This fee is not charged by AAG but it may be charged by an affiliate of AAG. If you have previously purchased a GLWB product, your new allocation may be reduced (including to zero) or increased following your enrollment into the Managed Account service. Please read the Summary Disclosure Statement carefully. You may cancel your enrollment in the service at anytime.

DISCLAIMERS

AAG uses reasonable care, consistent with industry practice, in providing services to you. AAG, your plan sponsor and/or the recordkeeper or IRA account provider, as applicable, do not guarantee the future performance of your account or that the investments we recommend will be profitable. Investment return and principal value will fluctuate with market conditions, and you may lose money. The investments we may recommend or purchase for your account, if applicable, are subject to various risks, including, without limitation; business, market, currency, economic, and political risks. AAG does not provide advice for, recommend allocations of, or manage individual stocks (including employer stock), self-directed brokerage accounts, guaranteed certificate funds, or employer-directed monies, even if they are available for investment in your plan or IRA. We do not select the investment options available for investment in your plan or IRA. By recommending allocations among the available investment options, we are not endorsing the selection of particular investment options available in your plan or IRA.

AAG, the plan sponsor and/or the recordkeeper or IRA account provider, as applicable, will not be liable to you for any loss caused by (1) our prudent, good faith decisions or actions, (2) following your instructions, or (3) any person other than AAG or its affiliates who provides services for your account. Neither AAG nor your Plan Sponsor will be liable to you for any losses resulting from your disclosure of your personal information or your PIN number to third parties even if the purpose of your disclosure is to enable such person to enroll you in, or cancel your enrollment in, Advisory Services. AAG is not responsible for voting proxies for the securities in your account. We do not guarantee that the services or any content will be delivered to you uninterrupted, timely, secure, or error-free.

TO THE MAXIMUM EXTENT PERMITTED BY LAW, AAG DISCLAIMS ALL REPRESENTATIONS AND WARRANTIES, EXPRESS OR IMPLIED, WITH RESPECT TO THE SERVICES AND THE SERVICE CONTENT, AND ALL INFORMATION DERIVED FROM THEM, INCLUDING, BUT NOT LIMITED TO, IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, QUALITY, TIMELINESS, ACCURACY, AND IMPLIED WARRANTIES ARISING FROM COURSE OF PERFORMANCE OR COURSE OF DEALING. IN ADDITION, AAG DOES NOT WARRANT THAT THE SERVICE OR CONTENT CONTAINED IN IT WILL BE UNINTERRUPTED, ERROR FREE, FULLY AVAILABLE AT ALL TIMES OR THAT ANY INFORMATION OR OTHER MATERIAL ACCESSIBLE THROUGH THE SERVICE IS FREE OF ERRORS OR OTHER HARMFUL CONTENT.

LIMITATION OF LIABILITY

YOU UNDERSTAND THAT IN NO EVENT WILL THE PLAN SPONSOR, IF APPLICABLE, AAG OR ITS OFFICERS, DIRECTORS, SHAREHOLDERS, PARENTS, SUBSIDIARIES, AFFILIATES, EMPLOYEES, CONSULTANTS, AGENTS, LICENSORS OR ANY DATA PROVIDER BE LIABLE FOR ANY CONSEQUENTIAL, PUNITIVE, INCIDENTAL, SPECIAL OR INDIRECT DAMAGES, LOSS OF BUSINESS REVENUE OR LOST PROFITS, WHETHER IN AN ACTION UNDER CONTRACT, NEGLIGENCE OR ANY OTHER THEORY EVEN IF WE ARE ADVISED OF THE POSSIBILITY OF SUCH.

INDEMNIFICATION

You agree to indemnify, defend and hold harmless AAG and its officers, directors, shareholders, parents, subsidiaries, affiliates, employees, consultants, agents and licensors, your employer, the Plan Administrator and/or recordkeeper, Plan Sponsor, Plan trustees, Plan fiduciaries, their agents, employees, and contractors or IRA provider, as applicable, from and against any and all third party claims, liability, damages and/or costs (including but not limited to reasonable attorneys fees) arising from your failure to comply with this Agreement, the information you provide us, your infringement of any intellectual property or other right of a third party, or from your violation of applicable law.

GENERAL PROVISIONS

AAG acknowledges that, as a registered investment adviser, it owes a fiduciary duty to participants with respect to investment advice (Online Investment Advice) and investment management (Managed Account). AAG is not a fiduciary with respect to guidance (Online Investment Guidance). AAG may not assign this Agreement (within the meaning of the Investment Advisors Act of 1940 ("Advisors Act")) without your consent. You may not assign this Agreement. Unless otherwise agreed to in your plan's agreement with AAG, if applicable, this Agreement is entered into in Denver, Colorado and governed by and construed in accordance with the laws of the State of Colorado, without regard to its conflict of law provisions. You agree that proper forum for any claims under this Agreement shall be in the courts of the State of Colorado for Arapahoe County or the United States District Court, District of Colorado. If you are a participant in a retirement plan, please contact your plan sponsor to determine proper venue for actions brought under this agreement. The prevailing party shall be entitled to recovery of expenses, including reasonable attorneys' fees. This agreement constitutes the entire Agreement between you and AAG with respect to the subject matter herein. You agree that any amounts owed to you arising under this contract shall incur interest no less than the current Federal Funds rate plus 3% per annum. If for any reason a provision or portion of this Agreement is found to be unenforceable, that provision of the Agreement will be enforced to the maximum extent permissible so as to affect the intent of the parties, and the remainder of this Agreement will continue in full force and effect. No failure or delay on the part of AAG in exercising any right or remedy with respect to a breach of this Agreement by you shall operate as a waiver thereof or of any prior or subsequent breach of this Agreement by you, nor shall the exercise of any such right or remedy preclude any other or future exercise thereof or exercise of any other right or remedy in connection with this Agreement. Any waiver must be in writing and signed by AAG. All terms and provisions of this Agreement, including without limitation "Disclaimers", "Limitation of Liability", "Indemnification", "Intellectual Property", and "Privacy Policy", which should by their nature survive the termination of this Agreement, shall so survive. This Agreement will automatically terminate upon termination of your Plan's agreement with AAG, or upon termination of your Plan's service agreement with its recordkeeper, if applicable. Nothing in this Agreement shall be construed to waive compliance with the Advisors Act, the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), if applicable, or any applicable rule or order of the Department of Labor under ERISA. AAG shall not be liable for any delay or failure to perform its obligations hereunder if such delay or failure is caused by an unforeseeable event beyond its reasonable control, including without limitation: act of God; fire; flood; earthquake; labor strike; sabotage; fiber cut; embargoes; power failure; lightning; suppliers failures; act or omissions of telecommunications common carriers; material shortages or unavailability or other delay in delivery; government codes, ordinances, laws, rules, regulations or restrictions; war or civil disorder, or acts of terrorism. AAG reserves the right to modify this Agreement at any time. You agree to review this Agreement periodically so that you are aware of any such modifications. Your continued participation in Advisory Services shall be deemed to be your acceptance of the modified terms of this Agreement. This Agreement shall inure to the benefit of AAGs successor and assigns.

All securities transactions that occur as a result of the advisory services are executed by GWFS Equities, Inc., ("GWFS") an affiliated broker/dealer. GWFS may receive 12b-1 fees or other compensation from the investment option providers, including mutual funds and their sponsors and affiliates, for the sale of fund shares allocated to participant accounts and/or for other services. The amount of 12b-1 fees and/or other compensation GWFS may receive from an investment provider varies. In addition, registered representatives of GWFS may provide wholesaling, direct sales, enrollment and/or communication services to retirement plans and their participants for which AAG may also provide its services. For these services, GWFS may receive fees either from the plan or from the investment providers (fund families), as described above. Participants in the Online Investment Advice or Managed Account service may have allocations to investment options that result in GWFS receiving 12b-1 fees or other compensation. Allocations to the investment options are solely determined and based on Morningstar Investment Management's software, not determinations made by AAG. The compensation paid by AAG to Morningstar Investment Management for Morningstar Investment Management's proprietary software advice program does not vary based on the allocations made or recommended by Morningstar Investment Management. Because Morningstar Investment Management is unaffiliated with AAG and GWFS, AAG does not believe there is a conflict of interest. However, in all instances, AAG's affiliation with GWFS is disclosed.

INTELLECTUAL PROPERTY

All content provided as part of Advisory Services, including without limitation names, logos, methodologies, and news or information provided by third parties, is protected by copyrights, trademarks, service marks, patents, or other intellectual property and proprietary rights and laws ("Intellectual Property") and may constitute trade secrets, as defined by applicable law. All such Intellectual Property is the property of their respective owners and no rights or licenses are granted to you as a result of your participation in Advisory Services.

PRIVACY POLICY

AAG protects your privacy. We have strict policies in place to keep your personal information private. A summary of AAG policies and procedures to protect the privacy and security of your personal information is set forth below.

Types of Information We Collect: AAG may collect personal information about you from your plan sponsor or employer, if applicable, from applications or other forms that you complete, from your plan or service provider, and from our affiliates you have conducted business with. Such information includes without limitation; your name, address, age, salary, number of dependents, plan account balances and contributions. You may provide us with additional personal information about your investments and preferences at any time. We also keep records of all transactions in your account and any communications about your account. AAG does not specifically collect your social security number for use with the service.

Security of Your Information: We have strict procedures to protect your privacy. They include physical, administrative, and technical safeguards.

Access to Information: The only employees who have access to your personal information are those who need it to service your account, or to provide you with products or services.

Our Information-Sharing Practices: AAG will not disclose, sell, share, or reveal your personal information except in the following circumstances:

- We have your authorization to share your personal information with third parties;
- We need to share your personal information with our affiliates who provide a product or service you have requested or to maintain, service or administer your account (for example, our affiliated broker-dealer that executes transactions in your account; such affiliates do not have the right to use your personal information other than in the performance of services necessary to assist us);
- If applicable, we need to share your personal information with your employer, plan sponsor and/or plan provider in order to provide the services described in our contract with your employer, plan sponsor and/or plan provider; or
- We are required by law to disclose your personal information (for example, in response to a subpoena, governmental or regulatory request, or to protect against fraud or other illegal activity).

Analysis: We may perform analyses based on data about our customers. Such data will not contain personally identifiable information.

Our Treatment of Information about Former Customers: Protecting your privacy goes beyond our relationship with you as a user of Advisory Services. If this relationship ends, we will not share your personal information with third parties, except as law permits.

Customer Right To Change Information: To correct, amend or supplement your personal information, you may contact us at your existing toll-free customer service number.

ABOUT ADVISED ASSETS GROUP, LLC

AAG, a wholly owned subsidiary of Great-West Life & Annuity Insurance Company, is a registered investment adviser with the Securities and Exchange Commission.

Since its inception, AAG has focused on establishing, refining and continually improving the process of investment planning for plan sponsors, plan participants and IRA account holders. By blending best practices investment approaches with personalized plan data and leading industry knowledge and expertise, AAG aspires to create effectively-built, diversified retirement solutions that maximize outcomes for plan participants while minimizing fiduciary risk to plan sponsors.

Additional information about the services provided by AAG may be found in AAG's Form ADV Part II, which is available free of charge on-line at www.adviserinfo.sec.gov or upon request by calling AAG at the toll free number listed in your communication materials or writing AAG at: 8515 East Orchard Road, Greenwood Village, Colorado 80111.

Interest in Participant Transactions. AAG, its officers and employees may purchase securities for their own accounts and these securities may be the same as those recommended to, or invested for, you (e.g., shares of the same mutual fund).

ABOUT MORNINGSTAR INVESTMENT MANAGEMENT

AAG has teamed with Morningstar Investment Management, a recognized industry leader in asset allocation and investment analytics tools, to provide the underlying investment advice and portfolio management methodology that will power Advisory Services.

Morningstar Investment Management is a leading independent provider of asset allocation, manager selection, and portfolio construction services. The company leverages its innovative academic research to create customized investment advisory solutions that help investors meet their goals.

AAG reserves the right to replace the Independent Financial Expert in its sole discretion and without your approval. AAG will notify you of any fee changes resulting from the Independent Financial Expert being replaced. In the event AAG terminates its relationship with the current Independent Financial Expert and is unable to contract with a suitable replacement Independent Financial Expert, this Agreement shall automatically terminate upon written notice from AAG.

Your investment line up and Managed Account allocations may include mutual funds issued by Great-West Funds and Putnam Investments or insurance products issued by Great-West, its parent company, or Great-West Life & Annuity Insurance Company of New York ("GW-NY"). Great-West Funds, Putnam Investments, their respective fund managers and GW-NY are affiliates of AAG. Morningstar Investment Management or its affiliates may provide asset allocation services for AAG affiliates for which fees may be paid. For the Great-West Funds offered within the Managed Account service, Morningstar Investment Management has agreed to waive these fees. For more information, please see the applicable fund prospectus.

For retirement plan participants, the investment options in your retirement plan are selected solely by the plan or plan sponsor. In addition, AAG does not receive compensation from its parent company or any of its affiliate in bringing or offering Insurance Products or Directed Options to AAG's advisory clients.

ACCEPTANCE OF TERMS AND CONDITIONS OF ADVISORY SERVICES AGREEMENT

If you agree to the terms and conditions set forth herein, you will be enrolled in the service you requested that is offered under Advisory Services. Your acceptance of the terms and conditions shall signify your consent to be bound by the applicable provisions of this Agreement, as they relate to the Online Investment Guidance, Online Investment Advice, or the Managed Account services. Please note that upon enrollment in the Managed Account service, any currently initiated transfers or transactions will be cancelled, unless the market has already closed for the day.

If you do not agree to the terms and conditions set forth herein, you will not be enrolled in the service you requested that is offered under Advisory Services.

The Prudential Insurance Company of America – Enrollment and Beneficiary Form

751 Broad Street • Newark, NJ 07102

NCPERS $16 PLAN Control No.: 92860

Please submit your complete enrollment form to your employer. Your employer will begin payroll deductions and forward your enrollment information to HealthSmart Benefit Solutions, Inc. Questions? Call 1-800-525-8056.

FOR EMPLOYER:

Please complete this section. Additionally, it is important that you review the form for complete information. All sections must be completed in order for The Prudential Insurance Company of America to process claims.

Please show date of first deduction _____ (Mo. Day Yr.)

EMPLOYER Unit No. _____

Return completed form to:
HealthSmart Benefit Solutions, Inc.
PO Box 16346
Lubbock, Texas 79490
1-800-525-8056
Email: NCPERS@healthsmart.com

Member Information ☐ New Member Enrollment ☐ Open Enrollment ☐ Change of Beneficiary

Last Name | First Name | MI

Street Address | City | State | ZIP code

Social Security Number ___ – ___ – ____

Primary Phone Number _____ _____

Your Date of Birth (mm/dd/yyyy) _____/_____/_____

Date of Employment

_____/_____/_____ Actively at work?* ☐ Yes ☐ No – If no, you are not eligible for this coverage. ☐ Male ☐ Female

*Active Work Requirement: A requirement that a member be actively at work as normally required by the employer or as predetermined by the member's Public Employee Retirement Systems group on the date of the insurance is to begin.

I declare the above statements and answers are complete and true and understand they are the basis for providing life insurance under a plan (or plans) issued by The Prudential Insurance Company of America (Prudential) to the National Conference on Public Employee Retirement Systems (NCPERS), in which I will participate upon becoming insured. I hereby authorize my employer to deduct from my wages amounts equal to the contributions required for me toward the premiums for Group Insurance under the NCPERS plan issued by Prudential. A photographic copy of this authorization shall be as valid as the original. The effective date of coverage will be the first day of the month following payment of my contribution through payroll deductions. I understand that my member coverage will be delayed if I am not actively at work on the coverage effective date. Instead, my coverage will begin on the date I meet the actively-at-work and other insurance requirements for covered members.

National Conference on
Public Employee Retirement Systems

Prudential

Member Information

Last Name	First Name	MI	Social Security Number
			___-___-____

FLORIDA RESIDENTS – 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.

NEW YORK RESIDENTS – 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. **This notice ONLY applies to accident and disability income coverage.**

The District of Columbia requires insurers to provide the following notice to all employees being offered Accidental Death and Dismemberment, Accident Insurance and/or Critical Illness coverage:

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMAL ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

I have read and understand the terms and requirements of the fraud warnings included on the last page of this form.

Member Signature (Sign in ink.) _____ Date Signed _____

FOR INSUREDS WHO RESIDE IN MICHIGAN OR MINNESOTA ONLY – If you wish to enroll your spouse, domestic partner, and/or eligible child 18 years of age or older for Dependent Life and/or Accidental Death and Dismemberment Insurance coverage, your spouse, domestic partner, and/or each of your eligible children age 18 years or older must consent to such coverage by signing and dating this consent in the appropriate space(s) below. Coverage on your spouse, domestic partner, and/or eligible children age 18 or older will not become effective unless and until the requisite consent is provided.

Spouse/Domestic Partner Signature (Sign in ink.) _____ Date Signed _____

Child Signature (Sign in ink.) _____ Date Signed _____

Child Signature (Sign in ink.) _____ Date Signed _____

Please indicate your Primary and Contingent beneficiary designations on the next page.

Member Information

Last Name | First Name | MI | Social Security Number

Member Beneficiary Designations (to be completed by member or assignee, if assigned)

Please designate at least one primary beneficiary. Use a separate sheet if you want to name more than one primary beneficiary. If designating a Trust, Estate, or Corporation, please complete the corresponding fields. Do not name a beneficiary for Dependent Group Decreasing Term Life coverage; these benefits are paid to you while living. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

Primary Beneficiary

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	ZIP

Check one, if applicable:	☐ Trust ☐ Estate ☐ Corporation	Entity Name	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	ZIP

Contingent Beneficiary Designation

— Death benefits will be paid to the contingent beneficiaries if the primary beneficiary(ies) is not alive. Use a separate sheet if you want to name more than two contingent beneficiaries. If designating a Trust, Estate, or Corporation, please complete the corresponding fields.

Last Name	First Name	MI	Telephone Number
Social Security Number	Date of Birth	Relationship	Percentage
Street Address	City	State	ZIP

Check one, if applicable:	☐ Trust ☐ Estate ☐ Corporation	Entity Name	
Tax ID #/Tax Exempt #	Creation/Incorporation/Formation Date	Telephone Number	Percentage
Street Address	City	State	ZIP

Member Signature (Sign in ink.) _____ Date Signed _____

NCPERS is a non-profit organization that provides education and support to public employment retirement systems. NCPERS has no role in the administration of the life insurance program and the benefits are guaranteed solely by the insurance carrier. NCPERS is compensated solely for the use of its name, service marks, and mailing lists.

The plan is administered by HealthSmart. HealthSmart and Gallagher Benefit Services, Inc. are not affiliates of Prudential.

Group Decreasing Term Life, Dependent Group Decreasing Term Life, and Accidental Death and Dismemberment Insurance coverages are issued by The Prudential Insurance Company of America, a Prudential Financial company, 751 Broad Street, Newark, NJ 07102. Please refer to the Booklet-Certificate, which is made a part of the Group Contract, for all plan details, including any exclusions, limitations and restrictions which may apply. If there is a discrepancy between this document and the Booklet-Certificate/Group Contract issued by The Prudential Insurance Company of America, the Group Contract will govern. Contract provisions may vary by state. California COA # 1179, NAIC # 68241. Contract Series: 83500.

1424485
Ed. 04/16

For residents of all states except Alabama, Arkansas, the District of Columbia, Florida, Kentucky, Louisiana, Maine, Maryland, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, Utah, Vermont, Virginia, and Washington:
WARNING – Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

ALABAMA RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ARKANSAS, DISTRICT OF COLUMBIA, LOUISIANA and RHODE ISLAND RESIDENTS – 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.

KENTUCKY RESIDENTS – 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.

MAINE and WASHINGTON RESIDENTS – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company commits a crime. Penalties include imprisonment, fines, and denial of insurance benefits.

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

NEW JERSEY RESIDENTS – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NORTH CAROLINA RESIDENTS – Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant, knowing that the statement contains false information concerning a fact or matter material to the claim may be guilty of a class H felony.

PENNSYLVANIA and UTAH RESIDENTS – 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 material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO RESIDENTS – Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established
may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

VERMONT RESIDENTS – Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of a criminal offense under state law.

VIRGINIA RESIDENTS – Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Accelerated Death Benefit option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered "terminally ill". You may wish to seek professional tax advice before exercising this option.

EGI New Benefited Employee Enrollment Check List

Today's Date:_____ Date of Hire: _____

Employee Name:_____ SSN:_____

Agency Name & Number:_____ Benefit Specialist:_____

ELIGIBILITY & DEADLINES

❑

- All employees must work 80 hours per calendar month to be eligible and maintain eligibility
- The HIPAA Privacy Notice is available at (egi.wyo.gov) on the Publications page
- Deadline for newly eligible employees: must submit enrollment applications via paper or online portal within 31 days of eligibility (day coverage would begin) this includes any revisions to your elections
- Deadline for Qualifying Event changes is within 60 days of the event, you must submit paper or an online application for benefit change. (i.e birth, marriage, divorce etc.)
- Deadline for supporting documentation for dependents and/or a qualifying event is within 30 days of the application deadline

Yes
No

Determine if the employee & spouse both work for EGI covered employer?

State of Wyoming	University of Wyoming	Laramie County Comm. College
Central Wyoming College	Eastern Wyoming College	Western WY Comm. College
Northwest Comm. College	NWCCD	Casper College
WCDA	WY Infrastructure	Natrona CO School District
City of Casper	WY Pipeline	

- If yes, and children will be covered, *Split* coverage is required for health & dental
- If yes, but no children being covered, *employee only* coverage is required for both (cannot decline)

PREMIUMS

❑

- State Contribution – applies to Health, Dental and Employee basic Life only. All other benefits are 100% employee paid
- Use the online Calculator to determine your monthly employee portion of premium (egi.wyo.gov)
- As a new hire employee, you may have a double premium deduction from your paycheck if premiums could not be deducted from your first paycheck

BENEFITS

❑

Health, Dental & Life

- Training videos are available on our website for benefits. (egi.wyo.gov) on the training page
- Optional Dental – if waived/declined there is a 3 year waiting period to enroll
- Describe insurance plans available including deductibles
- Health and Dental insurance ID card will be sent to the employee by the insurance vendor

❑

Vision, Disability & Long Term Care

- Vision Enrollment Options (2 year commitment if enrolling & 2 year waiting period if waived)
- Employee Short Term and Long Term Disability – guarantee issue at new hire, see training video
- Genworth Long Term Care Website Information is on the Application. Employee must enroll online directly with Genworth

❑	**Flexible Spending Benefits – be sure to read through the Flex Booklet for all details**
	• Premium Tax Election
	  ○ Pre Tax - locks you into all benefit elections, changes only permitted with a Qualifying Event
	  ○ Post Tax - Not locked into benefit elections except for specific benefit commitments
	  ○ Elections remain in effect until you change them during Open Enrollment for the new year
	• Medical Reimbursement Accounts must be re-elected each year if you wish to participate
	  ○ This account is a use it or lose it account so plan accordingly
	  ○ Direct Deposit is available once the employee is set up in the State's accounting system.
	  ○ Flex deposits are pulled in the payroll month the deposit is due. (i.e. Jan. payroll is Jan. deposit)
	• Day Care Reimbursement Accounts must be re-elected each year if you wish to participate
	  ○ This account is a use it or lose it account so plan accordingly.
	  ○ Money must be in the account in order to be reimbursed.
	  ○ Direct Deposit is available once the employee is set up in the State's accounting system
	  ○ Flex deposits are pulled in the payroll month the deposit is due (i.e. Jan. payroll is Jan. deposit)

HR USE ONLY

- ❑ Provide the Employee Health/Dental/Life Application or Employee Portal Instructions
- ❑ Provide the Employee Voluntary Benefits Application or Employee Portal Instructions
- ❑ Provide the Employee the Flex Election form or Employee Portal Instructions
- ❑ Provide the Health, Dental and Life Benefit Plan Books to the employee
- ❑ Provide the Summary Benefit Comparisons (SBC, 4 total) to the employee
- ❑ Federal Requirement: Provide employee with the Health Insurance Marketplace Notice
- ❑ Add the new employee to the (eBMS) Employee Portal (egiportal.wyo.gov)
- ❑ Provide the employee a copy of this signed checklist for their records
- ❑ Email the completed/signed checklist to EGI.

_____ _____

Employee Signature Date

By signing this form, you acknowledge you understand the information contained on this document.

_____ _____

Benefit Specialist Signature Date

By signing this form, you acknowledge you have reviewed this information with the employee.

This completed form is required for all newly eligible employees. Enrollment will not be processed without.

Revised 10/2019

Employees' Group Insurance
Phone: 307-777-6835
Email: egi@wyo.gov
Website: egi.wyo.gov
Portal: egiportal.wyo.gov

2020 State Group Insurance Active Employee Monthly Rate Sheet

Effective January 1, 2020

HEALTH	2020 Premiums
$500/$1000 Ded.	
Employee	$1,046.42
Employee+Child(ren)	$1,588.88
Employee+Spouse	$2,106.81
Family	$2,422.40
Split ****	$1,211.20
$900/$1800 Ded.	
Employee	$1,017.10
Employee+Child(ren)	$1,544.36
Employee+Spouse	$2,047.77
Family	$2,356.28
Split ****	$1,178.14
$1500 High Deductible Health Plan	
Employee	$957.32
$3000 High Deductible Health Plan	
Employee+Child(ren)	$1,453.61
Employee+Spouse	$1,927.43
Family	$2,222.50
Split ****	$1,111.25
$2,000/$4000 Ded	
Employee	$947.55
Employee+Child(ren)	$1,438.39
Employee+Spouse	$1,907.25
Family	$2,192.98
Split ****	$1,096.49

DENTAL

Preventive Dental	
Employee	$22.15
Family	$48.92
Split	$24.46
Optional Dental	
Employee	$18.46
Family	$43.26
Split	$21.63

Life Insurance

00-39	50,000	3.14
40-44	50,000	3.40
45-49	50,000	4.92
50-54	50,000	7.36
55-59	50,000	13.41
60-64	32,000	13.04
65-69	21,000	16.31
70-74	14,000	17.55
75-79	9,000	18.27
80-84	6,000	19.72
85 & over	4,500	23.96

Dependent Life Rate	1.46

Your Contribution Calculation

Health Premium _____

Preventive Dental Premium * + _____

Optional Dental Premium + _____

Life Insurance Premium + _____

Total Premium = _____

Employer Contribution (Active Only) - _____

Employee Only	$928.65
Employee + Children	$1,412.50
Employee + Spouse	$1,852.74
Family	$2,121.00
Spilt ****	$1,070.68
AWEC/TP01	$928.65

Sub Total ** = _____

Dependent Life Premium *** + _____

Your Contribution = _____

* Preventive dental is required when health coverage is elected.

** If "Sub Total" is negative, put zero in the box.

*** Dependent Life cannot be paid for with employer contributions.

**** SPLIT COVERAGE:

If both spouses work for State, University and/or Community Colleges, Split coverage for family coverage is mandatory.

Note: If both spouses work for State, University,Community Colleges, and/or NCSD but no children are covered, single coveage is mandatory.

AWEC/TP01 Split: AWEC/TP01 recieves a single rate contribiton of (928.65)and spouse recieves a special contribution of (1,212.71)

Employees' Group Insurance Website

egi.wyo.gov

Employees' Group Insurance Benefit Application

Print Form

☐ New Enrollee ☐ Change Options ☐ Address or Name Change ☐ Change Deductible ☐ Open Enrollment

Employee Information

Employee SSN	
Agency Name/Number	
Employee Full Legal Name	
Address	
City, State, Zip	
Marital Status	Gender
Date of Hire	Date of Birth
Home Phone	Work Phone
Email:	

Dependent Infomation

*birth certificate or marriage certificate required to verify dependent eligibility

	Name	DOB	Gender	SSN
Spouse				
Child				
Child				
Child				
Child				
Child				
Child				

Benefit Election

Health	Dental
☐ Employee Only	
☐ Employee + Child	☐ Single
☐ Employee + Spouse	
☐ Family	☐ Family
☐ Split ** Agency _____	
☐ $500/1,000 Deductible	
☐ $900/1,800 Deductible	☐ Preventive Only
☐ $2,000/4,000 Deductible	☐ Preventive & Optional
☐ $1,500 (EO) HDHP	
☐ $3,000 (FAM) HDHP	

Life

☐ Employee Only ☐ Employee & Dependents ☐ Beneficiary Change

		%
Beneficiary Name Address / Relationship		
Beneficiary Name Address / Relationship		
Beneficiary Name Address / Relationship		
Contingent Beneficiary Address / Relationship		
Contingent Beneficiary Address / Relationship		
Contingent Beneficiary Address / Relationship		

I hereby accept the benefit elections as indicated above and authorize any required employee contributions to be deducted from my earnings through payroll deduction until cancellation of the coverage as outlined in the benefit plan booklet. I certify that any dependents listed above are eligible for coverage as outlined in the benefit plan booklet and I accept the responsibility of notifying the Employees' Group Insurance office of any changes for myself, my spouse or dependents that would affect eligibility for coverage, premium amounts or payments. Under the penalty of perjury, I declare that the information I have furnished, to the best of my knowledge and belief, is true, correct and complete.

Signature _____ Date _____

Withdraw or Decline Benefits

	Name	Health	Dental	Life
Employee		☐	☐	☐
Spouse		☐	☐	☐
Child		☐	☐	☐
Child		☐	☐	☐
Child		☐	☐	☐

I have been given an opportunity to participate in the benefits with the State of Wyoming group insurance program. The benefits have been explained to me and I understand that if I delay in enrolling until after the initial period of eligibility, I and/or my dependents will only be able to enroll during the State's open enrollment periods or in a special enrollment as provided in the benefits booklet.

Signature:_____

Date:_____

Full Match	Contract: (AWEC) (TP01)	Job Share: (3/4) (2/3) (1/2)	Agency Receipt: _____ Initials: _____

An Incomplete Application may delay the processing of your benefits.

Revised 9/2016

Preventive Dental Coverage - Preventive dental coverage is required if you have enrolled in the health insurance. The premium for dental is only single or family, so even with just an employee and spouse, it is still considered family. Preventive dental covers two cleanings per year (separated by at least 5 months) and certain x-rays. The preventive has no deductible and services are covered at 100%. Please see plan booklet for complete eligibility and benefits.

Optional Dental Coverage - Optional dental covers restorative or corrective work such as fillings, crowns etc. There is a $50 deductible per person with a maximum $100 deductible per family. After the deductible, the benefits are paid at 80% (of maximum allowable cost) for basic services and 50% (of maximum allowable cost) for major services. There is a limit to the benefits paid, which is $1,500 per person per calendar year. If an employee declines or withdraws from coverage, they will have to satisfy a three year waiting period to re-enroll. Please see plan booklet for complete eligibility and benefits.

Split Coverage - Split coverage is *family* coverage where two spouses (with children) each pay half the cost of family premium, and each employee's agency pays half the state contribution. This occurs when both spouses work at an entity covered through the State of Wyoming; such as a state agency, University of Wyoming, and community colleges. When two employees are on split coverage, Employees' Group Insurance will maintain the coverage using the SSN of the employee who has been employed the longest. *If two married employees are covered under this plan with no children, they must elect single (employee only) coverage.

High Deductible Health Plan (HDHP) - The HDHP works differently than the other plans. The HDHP prescription benefit is part of the medical benefit, and **all prescriptions filled will be subject to deductible and co-insurance.** Another difference in the administration of this type of plan is how the deductible is applied. If coverage is not single coverage, then the total deductible is $3,000, and no claims will be paid until the $3,000 has been met, which could occur in claims for only one person. For further information on all plan options, please see your plan booklet. Participants in the HDHP are eligible to participate in a Health Savings Account.

Change Enrollment Options –If you experience a qualifying event, which allows you to add and/or drop dependents, the *applications must be submitted to your benefit specialist within 60 days from the date of the event*. Upon submitting the applications, supporting documentation of the qualifying event must also be submitted and is due within 30 days from the application deadline. **Post-tax insurance premiums** - if your insurance premium is deducted from your payroll *after* taxes, you can drop coverage or dependents without any documentation.

***Dependent Documentation** - When changing your enrollment options to include adding any eligible dependent, you must provide documentation that verifies the eligibility of that dependent, such as a birth certificate for a child and a marriage certificate for a spouse. If documentation is not received within 30 days from the application deadline, it will be null and void. The dependent will not be added and can be enrolled during an open enrollment period, provided the documentation is provided at that time.

Please check the Appropriate Qualifying Event and Date of Event		
	Event Date / /	**Marriage** - a marriage certificate is required. Coverage is effective the date of marriage
	Event Date / /	**Divorce** - the first and last page of the divorce decree
	Event Date / /	**Birth/Adoption** - a birth certificate or paperwork showing placement or final adoption decree. Coverage is effective the date of birth or placement in home.
	Event Date / /	**Loss of Coverage** - documentation from employer or insurance provider indicating WHO lost coverage, WHEN coverage ended, and WHY coverage ended. Loss of coverage must be because you are no longer eligible versus a voluntary cancellation of coverage.**
	Event Date / /	**Obtained Coverage** - documentation that you or your dependent has obtained other group coverage and should include WHO has obtained coverage and effective date of coverage.**
	Event Date / /	**Other -**

State of Wyoming
Administration & Information
Employees' Group Insurance
2001 Capitol Avenue - B3
Cheyenne, WY 82002
307-777-6835 or toll free in WY 1-800-891-9241

**Changes are effective the first of the month following the date of the event and receipt of your application, unless otherwise stated.

Print Form

Print Form

Employees' Group Insurance Voluntary Benefit Application

☐ New Enrollee ☐ New Enrollee (TP01)	☐ Change Options

EMPLOYEE INFORMATION

Agency Name And Number			
Employee Name (Full Legal)		SSN	
Address			
City	State	Zip	
Date Of Hire	Date Of Birth	Marital Status ☐Single ☐Married	Gender ☐Male ☐Female

COVERAGE ELECTION

SEE BACK OF FORM FOR INFORMATION REGARDING THESE BENEFITS

Vision

☐ Employee Only
☐ Employee + 1
☐ Family

_____

☐ Plan B
☐ Plan C

Dependent Name**	Date of Birth

Disability

☐ Short Term Disability (STD)
☐ Long Term Disability (LTD)

Earnings:_____
☐ Per Hour
☐ Per Week
☐ Per Month
☐ Per Year

Hours Worked Per Week:_____

Long Term Care

Long Term Care is available to our member with an underwriting process directly through Genworth.

TO APPLY
Simply Visit Online At
Www.Genworth.Com/Groupltc
- Enter Group Name: statewy
- Enter Access Code: groupltc
- OR Call 1-800-416-3624

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I also understand these benefits are 100% employee paid.

Signature: _____ Date: _____

WITHDRAWAL OR DECLINE

	Member's Name	Vision	STD	LTD
Employee				
Spouse				
Child				
Child				
Child				

I understand that by waiving or dropping vision, I must satisfy a 2 year waiting period. I understand that by waiving or dropping disability insurance I may incur penalties or denial to re-enroll at a later date.

Date:_____

Signature_____

****Documentation is required verifying dependent eligibility for vision coverage.**

Agency Receipt : _____Initials:_____

Incomplete forms may delay the processing of your application.

Rev. 9/2015

VSP VISION COVERAGE

Exams
Covered In Full After Copay.....Every 12 Months
Prescription Glasses
Lenses Covered In Full After Copay.....Every 12 Months
- Single Vision, Lined Bifocal, & Lined Trifocal Lenses.
- Polycarbonate Lenses For Dependent Children.

Frames—Plan C.....Every 12 Months
Frames—Plan B.....Every 24 Months
- Frame, Allowance After Copay.....$160
- Plus, 20% Off Any Out-Of-Pocket Costs.

OR
Contact Lens Care
Covered .....Every 12 Months
When you choose contacts instead of glasses, your $160 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your vision exam to ensure proper fit of contacts. If you choose contact lenses you will be eligible for a frame 12 months from the date the contact lenses were obtained. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or Vsp.Com Or 1-800-877-7195.

COPAYS
Exam.....$10.00
Prescription Glasses.....$25.00
Contacts.....No Copay Apply

Plan B....Employee Only.....$6.76/Month
Plan B....Employee Plus One.....$13.50/Month
Plan B...Employee Plus Two Or More.....$21.74/Month
Plan C...Employee Only.....$8.40/Month
Plan C...Employee Plus One.....$16.78/Month
Plan C...Employee + Two Or More.....$27.02/Month

IMPORTANT: If vision coverage is waived or dropped, there is a two year waiting period before members can enroll in the coverage. Elections for vision coverage are for two years, and may not be changed without a qualifying event.

DEPENDENTS: Documentation is required for dependents covered on the vision confirming they are eligible.

Short Term Disability

Long Term Disability

Standard insurance company provides voluntary short term disability (STD) and long term disability (LTD) insurance to eligible state of Wyoming employees who elect coverage. The State of Wyoming provides you with the opportunity to purchase voluntary STD and/or LTD insurance, which is designed to pay a benefit to you in the event you cannot work because of a covered illness or injury. This benefit replaces a portion of your income, thus helping you meet your financial commitments in time of need. A disability is a reduction in pay by at least 20%.

The Short Term Disability benefit is 66 2/3 percent of your Gross weekly earnings less any deductible income, such as Workers compensation pay, retirement pension pay, etc.
- Benefits are based on weekly earnings
- Benefits are paid weekly
- Benefits payable after 14 calendar days from the date Of disability; payable up to 180 days
- All accumulated sick leave must be used prior to benefit payout.

Short Term Disability Customer Service 1-800-368-2859

The Long Term Disability benefit is 60 percent of your gross Monthly earnings less any deductible income, such as Workers compensation pay, retirement pension pay, etc.
- Benefits are based on monthly earnings
- Benefits are paid monthly
- Benefits payable after 180 calendar days from the date of disability; payable up to age 65

Long Term Disability Customer Service 1-800-368-1135

If you are enrolling in disability at a later date:

Short Term Disability (STD) be aware when coverage is selected outside of your original eligibility period, a 60 day penalty applies if you file a claim in the first 12 months of coverage. After you have been enrolled for 12 months, that penalty does not apply and the normal 14 day waiting period will apply to any claim filed.

Long Term Disability (LTD) To enroll outside your original eligibility period, you must enroll online, directly through The Standard. Our group number is 645750. You will need to complete a Medical History Statement and may not be approved for coverage:

http://www.standard.com/mybenefits/wyoming/

Employees' Group Insurance (State of WY)
2001 Capitol Ave. Rm. B3
Cheyenne, WY 82002
307-777-6835 or 800-891-9241 (in WY)

Incomplete forms may delay the processing of your application.

ENROLLMENT FORM
STATE OF WYOMING FLEXIBLE BENEFITS PLAN

2020

NAME _____ **SS#** _____
PLEASE PRINT

AGENCY NAME _____ **AGENCY #** _____

REIMBURSEMENT ACCOUNTS

These elections must be made every year; they do not continue without a new election.

_____ **MEDICAL REIMBURSEMENT ACCOUNT**. Please fill in the blanks with the dollar amount you want deducted from your earnings **each month** $_____ . **This is not an option for Health Savings Account (HSA) participants**. (Maximum election $2,700/year)

_____ **DEPENDENT DAYCARE ACCOUNT**. Please fill in the blanks with the dollar amount you want deducted from your earnings **each month** $_____ . (Maximum election $5,000/family)

_____ **WRAP AROUND MEDICAL REIMBURSEMENT ACCOUNT:** This option is intended to complement the Health Savings Account. Please fill in the blanks with the dollar amount you want deducted from your earnings each month $_____. (Maximum election $2,700/year) Electing the Wrap Around Medical Reimbursement does NOT enroll you in the Health Savings Account. (See back of form for additional information)

INSURANCE PREMIUMS

This election will stay in force until it is changed in any November for the new year.

_____ **PRE-TAX INSURANCE PREMIUMS**. Check if you elect to pay your insurance premiums on a pre-tax basis. By this election, I understand that I **cannot** drop anyone or any part of my insurance plan without a qualifying family status change.

_____ **POST-TAX INSURANCE PREMIUMS**. Premiums are taken out of pay *after* taxes have been assessed. This change will stay in force until it is changed in any November for the new plan year effective date.

Newly Eligible Employees (New Hires)	Annual Election (Open Enrollment)
Effective Date is 1st of the month following receipt of election	Effective date is January 1, 2020
Deadline is 31 days from the date you are eligible for benefits.	Deadline is November 30th, 2019
Monthly amounts I have elected will be deducted from my regular paychecks beginning immediately and continuing through December 31, 2020	Monthly amounts I have elected will be deducted from my regular paychecks beginning on January 31, 2020 through December 31, 2020
This election is **irrevocable** and no modifications are allowed, except for a change in family or employment status.	
I agree to all the terms and conditions described in the Flexible Benefits Plan Booklet.	
I have read and understand all provisions of this form	

Please read the back of this form before making any election.
SEE BACK OF FORM FOR DIRECT DEPOSIT ELECTION

_____ _____
By signing I agree to the above information DATE

AGENCY RECEIPT:_____

DIRECT DEPOSIT OPTION

NAME: _____ **SSN:** _____

If you would like to receive direct deposit from Employees' Group Insurance (EGI), the State Auditor's Office requires that you complete an **IRS Form W-9 (http://sao.wyo.gov/vendor-resources)** to initiate a Vendor Number in the State accounting system and authorize direct deposit; we also need an original voided check. Complete the form and return it to EGI with this election form. We will process it in coordination with the State Auditor's Office to update the State accounting system. With direct deposit, your payments will be automatically deposited into your checking or savings account. Once you return the completed forms, your reimbursements will begin to be direct deposited as soon as authorize by the State Auditor's office.

☐ **Yes,** I would like to receive direct deposit for my flex reimbursement ☐ **No,** I DO NOT want direct deposit

Signature _____ Date _____

Medical Reimbursement Account (MRA) – reimbursement for eligible expenses, i.e., coinsurance, deductibles and most medical expenses not covered by insurance including dental and vision expenses. The total monthly deductions elected for the Medical Reimbursement Account for the period of January 1 through December 31 may not exceed $2,700. **You are not eligible to enroll in this option if you are participating in a Health Savings Account. You may participate in the Wrap Around Medical Reimbursement Account (see below).**

Dependent Day Care Account (DCA) – reimbursement of expenses incurred for day care, home care, or child care for care of a dependent child under age 13, a disabled child of any age, a disabled spouse or a disabled dependent parent. The total monthly deductions elected for the Dependent Day Care Account for the period of January 1 through December 31 may not exceed $5000 for you and your spouse together ($2500 in the case of a married individual filing a separate tax return for 2019 OR the lesser of your (after subtracting all Flexible Benefit Plan deductions) or your spouse's earned income for the 2019 Plan Year.

- Money must be in the account to be reimbursed.
- Reimbursement can only be made for services as they are incurred.
- See your Flex Plan Booklet for further details of the program.

Wrap Around Medical Reimbursement Account (WMRA) – Intended for individuals participating in a Health Savings Account (HSA). Only expenses that are not allowed under the health plan are eligible for reimbursement, i.e., vision or dental services. The total monthly deductions elected for the Wrap Around Medical Reimbursement Account for the period of January 1 through December 31 may not exceed $2,700**.** Electing to participate in the Wrap Around Medical Reimbursement Account does **not** enroll you in a Health Savings Account.

Health Savings Account – Must be enrolled in the $1500 or $3000 deductible plan to participate. See your Benefit Specialist for additional information regarding eligibility and enrollment and/or our website for our HSA brochure (egi.wyo.gov) Electing to participate in the Wrap Around Medical Reimbursement Account does **not** enroll you in a Health Savings Account.

Pre Tax Insurance Premiums

When electing before tax premiums, your insurance premiums are taken out of your gross pay *first* and *then* the rest of your wages are taxed, reducing your taxable income. When selecting this option you cannot drop persons or coverage without a qualifying status change. PLEASE see the Flexible Benefits Plan Booklet for further details regarding this benefit. Once this election is made it will stay in effect until you change it due to a qualifying event, OR in any November for the new plan year.

Post Tax Insurance Premiums

When electing after tax premiums, your gross pay is taxed and *then* your insurance premium is deducted from your net pay (take home pay). When electing this option, you can drop coverage or person without a qualifying event (subject to plan provisions). PLEASE see the Flexible Benefits Plan Booklet for further details regarding this benefit. Once this election is made it will stay in effect until you change it due to a qualifying event, OR in any November for the new plan year.

NOTE: Deductions for the Plan Year beginning in January are taken from your January paycheck.
Please contact your Benefit Specialist or the Employees' Group Insurance office (777-6835) if you have any questions.

Revised 9/2019

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

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. Eligible employees are:
  - ☐ 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 will guide you through the process. Here's the employer information you'll enter when you visit 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 would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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)

WPEA/SEIU LOCAL 1990
307-635-7901
Fax 307-637-3932
Email: wyo.public.employees@att.net
Website: wyomingpublicemployees.org

WPEA - POLITICAL ACTION COMMITEE (PAC) ENROLLMENT FORM

WPEA/PAC is an optional member participation program which supports candidates who are supportive of public employee issues. Only WPEA/PAC member donations are used to support the endorsed candidates seeking the five elected offices, legislative, and Board of Trustees candidates for Laramie County School District No. 1. WPEA membership dues cannot be used for any PAC endorsements. If you wish to become a PAC member, a minimum of $1 or an amount of your choice can be payroll deducted along with your WPEA dues.

Name _____

Agency _____

____ I wish to become a member of PAC. Please deduct S1.00 a month along with my WPEA dues.

____ Please deduct for PAC _____ $2.50, _____ $5.00, _____ $7.50, _____ $10.
Other $ _____ amount to be deducted.

____ I do not choose to participate in PAC at this time.

Wyoming Public Employees Association/SEIU Local 1990

State Employee Payroll Deduction Authorization

Name _____ Date _____

Address _____ City _____ Zip _____

Agency _____ Social Security # _____ Home Phone _____

Email _____ House District _____ Senate District _____

Auditor, State of Wyoming: You are hereby requested to withhold dues and other designated deductions in the amount approved in accordance with current WPEA bylaws from my salary each month and forward that amount to the Wyoming Public Employees Association. I understand and agree that this deduction authorization does not constitute recognition by the State of Wyoming of the WPEA as a bargaining agent for me or other employees, and I agree that I will not, either individually or collectively as a member of a group or organization, assert or contend in any way whatsoever that it does constitute such recognition.

NOTE: WPEA Board Policy requires a 45-day waiting period for grievance/dismissal appeal representation of new members. Signature X _____

CARD CODE 1–4	AGENCY 5–6		EMPLOYEE NUMBER 11–16	USER ID 17–18		CODE 20–22	AMOUNT 23–29
				3 2		1 A N	

DUES	PAC	INS

WPEA/SEIU LOCAL 1990
Benefits for Members Only:

Legislative Input via Registered Lobbyists — Grievance Representation
Personnel Rules Negotiations — Employee Information Network
$3000 AD&D Policy AIL & AD&D Free Policy Plus Optional Policies*
Legal Shield & Identity Theft Program* — Long Term Care Insurance *
VSP Eye Care Plan* — PERKS Discount Card

**Fee Based Programs*

Invite a Co-Worker to Join Today!

Credit For Prior Service

I have prior State of Wyoming or University of Wyoming service and may be eligible for additional service time. My prior eligibility service is approximately:

IF NO PRIOR SERVICE – CHECK HERE_____

Employer	From:	To:

I hereby authorize State Parks and Cultural Resources to contact any prior employer to verify this service. I certify that all information provided by me is in connection with this claim and contains no willful misrepresentation or falsifications and that the information is true and complete to the best of my knowledge and belief.

Name (Printed)

_____

Signature

_____

Date:

_____

If employment was under another name, Please list that other name below:

Social Security Number:

_____

Department of Administration & Information

General Services Division

ID / Card Access / Key / Parking Permit Agreement

Employee Name: _____

First *Middle* *Last* *(Preferred First Name)*

Office Phone: _____ ***Birth Date:*** _____

Personal Vehicle(s): _____

Make/Model *License#* *Parking Permit #* *Permit Type*

(Make/Model) *License#* *Parking Permit #* *Permit Type*

(Make/Model) *License#* *Parking Permit #* *Permit Type*

Employee Status **(circle one):** **Permanent** **Temporary** **Contract**

Job Title: _____

Agency/Division: _____

Building: _____

Card/Permit Type: **(circle one)** **ID/Access Card** **Parking Permit** **Key**

I, the undersigned, acknowledge receipt of the ID/Access Card/Key/Parking Permit designated below. I also agree not to loan, transfer, give possession of, misuse, modify, or alter the designated ID/Access Card/Key or parking permit. I further agree not to cause, allow or contribute to the making of any unauthorized copies of these cards/keys or permit.

I understand and agree that I will annually produce this ID/Access Card/Key or parking permit for inventory verification. I understand and agree to return ID/Access Card/Key or parking permit upon transfer to another Department, or termination of my employment with the Department listed above.

Employee E-mail Address: _____

Employee Name **Printed** ***(please print full name):*** Do not sign until you are at A&I. Take driver's license for ID purposes.

Employee Signature: _____

Date: _____

Agency Authorization Signature: _____

Agency Authorization Name **Printed*:*** _____ ***Date:*** _____

Access To: _____

Building(s): _____

Door(s): _____

Room(s): _____

Access Time(s): **(circle one)** 6am-7pm M-F | 6am-9pm M-F | 24x5 (M-F all hours) | 24x7 | 6am-7pm 7days/week | 6am-9pm 7days/week

Office Use Only: _____

General Services Approval: _____ ***Date:*** _____

Access Card/Key/Parking Permit Number: _____

Issue Date: _____ ***Expiration Date:*** _____

No doors shall be blocked open for ***any*** reason.

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here | **Signature of U.S. person** ▶ | **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint*. You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Wyoming State Parks and Cultural Resources Wellness Program

Purpose: State Parks and Cultural Resources would like to establish a work environment that promotes a healthy lifestyle and improves morale.

Applicability: The Wellness Program applies to all permanent and temporary State Parks and Cultural Resources employees. If participating in the Wellness Program you and your supervisor must sign the attached Authorization form. The Authorization form will be turned in to Jacqueline Sanfilippo.

Program: Employees participating in the wellness program will be encouraged to reach 13 hours of exercise each month. Employees are authorized, with supervisor approval to consolidate their two fifteen (15) minute breaks (in lieu of taking your regular morning and afternoon breaks) and combine it with their lunch break allowing them thirty (30) extra minutes each day for physical activity. The other option, with supervisor approval, is authorizing employees to combine their two fifteen (15) minute breaks each day (in lieu of taking your regular morning and afternoon breaks, you may not combine multiple days of breaks to use at one time) using this thirty (30) minutes at the beginning or the end of their workday to participate in a wellness activity. Wellness can be done during work hours (15-minute breaks or 30 extra minutes for lunch) or during personal time (before/after work, weekends, etc.)

Program Management: Management of this program is at the supervisory level (supervisors may revoke wellness program privilege at any time). A Google Sheet has been created to log your exercise for the month. To access this Google Sheet please contact Stacy Sprengeler or Jacqueline Sanfilippo, once the sheet is shared, you will be able to update your personal exercise log. You will then enter time active (in minutes) and a vague description of your activity (run, walk, weights, spin, etc.). You must have your log updated by the first Tuesday of each month. The Google Sheet will be locked from further changes each 1st Tuesday for the previous month's log.

Rewards: The Director has the authority to grant up to 16 hours of personal leave per year and has agreed to the following; Employees who complete 13 hours a month of physical activity for 6 consecutive months (total of 78 active hours) are eligible for up to 8 hours of personal leave through the wellness program. Temporary employees can combine breaks, but cannot be rewarded personal leave.

HAPPY HEALTHY LIVING!

Authorization

I UNDERSTAND THE PURPOSE, PROCEDURES, RISKS, AND BENEFITS OF PARTICIPATING IN THE SPCR WELLNESS PROGRAM. ALL OF MY QUESTIONS HAVE BEEN ANSWERED. I AM FREE TO WITHDRAW FROM THE PROGRAM AT ANY TIME. MY PARTICIPATION IN THE WELLNESS PROGRAM MAY BE ENDED BY SPCR FOR ANY REASON. A COPY OF THIS SIGNED CONSENT FORM WILL BE AVAILABLE TO ME AT MY REQUEST.

_____	_____	_____
Participant's Printed Name	Division	Section

_____	_____
Participant's Signature	Date

_____	_____
Supervisor's Signature	Date

WAIVER, RELEASE OF ALL CLAIMS AND HOLD HARMLESS AGREEMENT FOR: STATE PARKS AND CULTURAL RESOURCES WELLNESS PROGRAM

Please read this form carefully and be aware that, in signing up and participating in the above program, you will be waiving and releasing all claims for injuries arising out or sustained while participating in this program, other than valid workers compensation claim.

In registering for the program, you are agreeing as follows:

As a participant in the wellness program, I recognize and acknowledge this is purely voluntary and there are certain risks however minor, of physical injury and I agree to assume the full risk of any injuries, including death, damages, or loss which I may sustain as a result of participating in any and all activities connected with or associated with such program. I further recognize and acknowledge that activities involving even slight or moderate exertion can be hazardous and involve some risks of injury.

I agree to waive and relinquish any and all claims that I may have as a result of participating in State Parks and Cultural Resource's Wellness Program against the State of Wyoming, any and all other participating or cooperating governmental units, officers, agents, servants, and employees of the governmental bodies for any injuries that I might sustain while participating in the program, other than a valid workers compensation claim. (The parties described in the preceding sentence are referred to as "released parties" in the remainder of the Agreement.)

I do hereby fully release and discharge the State of Wyoming and the other released parties from any and all claims from injuries, including death, damage or loss which I may have or which may accrue to me or my heirs, on account of my participation in the wellness program, other than a valid workers compensation claim.

I further understand and agree that the terms such as "participation," "program," and "activities," referred to in this agreement, include all exercises and physical movements of any natures while I am participating in the program.

I understand the nature of the program for which I am registering, and have read and fully understand this Waiver, Release, and Hold Harmless Agreement. I further understand that any advisements or warnings of this particular risk of this program that I subsequently receive will be incorporated by reference into and become a part of this agreement.

Name of Participant (please print) _____

Signature of Participant _____Date_____