NAME CORRECTION FORM
(Must be completed by the Employee)

DATE: _____

PLEASE PRINT

EMPLOYEE NAME: _____

SOCIAL SECURITY # _____

OLD NAME: _____

NEW NAME _____

ITEMS NEEDED TO CHANGE NAME IN THE SYSTEM

☐ MARRIAGE
- NEW SOCIAL SECURITY CARD
- MARRIAGE LICENSE

☐ DIVORCE
- NEW SOCIAL SECURITY CARD
- DIVORCE DECREE (name change page only)

You are also required to complete the following forms for either status change:

- PROFIT SHARING BENEFICIARY
- W-4 – FEDERAL FROM
- STATE FORM
- NEW I-9 (INCLUDE NEW DRIVERS LICENSE AND SOCIAL SECURITY CARD)
- LIFE INSURANCE ENROLLMENT FORM AND BENEFICIARY CARD

EFFECTIVE DATE OF CHANGE: _____

These forms may be e-mailed to beth@ucpcark.org or mailed to Human Resources at 9720 N. Rodney Parham, Little Rock, AR 72227

UNITED CEREBRAL PALSY PROFIT SHARING PLAN
DESIGNATION OF BENEFICIARY

PARTICIPANT: _____

I hereby acknowledge receipt of the Summary Plan Description and agree to abide by all of the rules and regulations set forth in the Plan. The following applies to me (select one):

( ) I have recently become a Participant of the Plan and I hereby make an election of beneficiary (ies)

( ) I am already a Participant of the Plan and I hereby update my DESIGNATION OF BENEFICIARY form for death benefits to be paid under the Plan.

Regarding any amount payable under the Plan by reason of my death, I make the following election (select the one option that applies to you):

1. ( ) MARRIED PARTICIPANT

I understand that the death benefit must be paid to my surviving spouse, unless my spouse consents in writing to an alternative beneficiary. The Plan Administrator has provided me with a detailed explanation of these rights concerning the death benefit (PRE-RETIREMENT SURVIVOR BENEFIT EXPLANATION and ELECTION TO WAIVE PRE-RETIREMENT SURVIVOR BENEFIT, WITH SPOUSAL CONSENT)

I understand that I must immediately inform the Plan Administrator of any change in my martial status.

Understanding my options, I choose to:

( ) keep my spouse as primary beneficiary. But if my spouse does not survive me, I name as contingent beneficiary (ies)

_____

_____

( ) name someone other than my spouse as the primary beneficiary. I understand that my spouse must agree to this waiver.

2. ( ) UNMARRIED PARTICIPANT

I designate as beneficiary (ies) the person (s) named below. However, if I thereafter marry, this will revoke the designation. I will therefore immediately inform the Plan Administrator of any change in my martial status.

PRIMARY BENEFICIARY (IES) and relationship: _____

_____

_____

CONTINGENT BENEFICIARY (IES) and relationship: _____

_____

_____

EXECUTED this _____ day of _____, 20____.

_____ _____

Witness Signature of Participant

_____

Birth Date Social Security Number

UNITED CEREBRAL PALSY PROFIT SHARING PLAN
PRE RETIREMENT SURVIVOR BENEFIT EXPLANATION

PARTICIPANT:

This form explains the pre-retirement death benefit under the Plan. The pre-retirement death benefit provides a benefit for your surviving spouse if you die prior to distributions from the Plan. Your surviving spouse will be entitled to 100% of your vested account balances in the Plan. You need to read the balance of this explanation only if you have designated, or wish to designate, someone other than your spouse to receive this death benefit.

If you are not married at the time of your death, then the death benefit will be paid to your designated beneficiary.

Pre-retirement death benefit. If you are married at the time of your death, then the Plan requires the Trustee to distribute your account balance (including the proceeds, if any, of life insurance contracts purchased on your behalf under the Plan) to your surviving spouse if your death occurs prior to commencement of benefits under the Plan and your spouse survives you. Generally, the Trustee may not commence payment of the pre-retirement death benefit prior to the date you would have attained the later of Normal Retirement Age under the Plan or age 62, without the consent of your surviving spouse. However, your surviving spouse may elect to have distribution of the pre-retirement death benefit at any time following your death. If, at the time of your death, your account balance (excluding amounts attributable to rollovers) is not greater than $5,000., the Plan Administration will direct the Trustee to make a lump-sum distribution to your surviving spouse.

Waiver Election. The Plan requires payment of the pre-retirement death benefit to your surviving spouse unless you have a valid waiver election in effect on the date of your death. To have a valid waiver, you must complete the waiver election form enclosed with this explanation. Your waiver election is not valid unless your spouse also consents in writing to your beneficiary designation or to any change in your beneficiary designation, unless your spouse is the sole primary beneficiary. A notary public or Plan representative also must witness your spouse's consent to the beneficiary designation. You may revoke a waiver election without your spouse's consent, but your spouse would have to consent to a new waiver. A waiver election is valid only for the spouse consenting to the waiver. Therefore, you should inform the Plan Administrator of any change in martial status.

Procedure. If you wish to have the pre-retirement death benefit distributed to your surviving spouse, then you do not need to make any election. If you wish to have the pre-retirement death benefit distributed to someone other than your surviving spouse, then execute the enclosed ELECTION TO WAIVE PRE-RETIREMENT SURVIVOR BENEFIT and SPOUSE'S CONSENT TO WAIVER OF PRE-RETIREMENT BENEFIT forms. We also have enclosed a DESIGNATION OF BENEFICIARY form.

If you have questions regarding the information provided in this explanation, or you wish further information, please contact the Plan Administrator.

Form W-4 (2016)

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

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

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

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

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

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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

Personal Allowances Worksheet (Keep for your records.)

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

For accuracy, complete all worksheets that apply.

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

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2016

1 Your first name and middle initial	Last name	2 Your social security number
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. Note: If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card. ▶ ☐	

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and • This year I expect a refund of all federal income tax withheld because I expect to have no tax liability. If you meet both conditions, write "Exempt" here ▶	7

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

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

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)
United Cerebral Palsy 9720 N. Rodney Parham Little Rock, AR 72227		71-0304327

Deductions and Adjustments Worksheet

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

1 Enter an estimate of your 2016 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1952) of your income, and miscellaneous deductions. For 2016, you may have to reduce your itemized deductions if your income is over $311,300 and you are married filing jointly or are a qualifying widow(er); $285,350 if you are head of household; $259,400 if you are single and not head of household or a qualifying widow(er); or $155,650 if you are married filing separately. See Pub. 505 for details . . . 1 $

2 Enter: { $12,600 if married filing jointly or qualifying widow(er); $9,300 if head of household; $6,300 if single or married filing separately } . . . . . 2 $

3 **Subtract** line 2 from line 1. If zero or less, enter "-0-" . . . . . 3 $

4 Enter an estimate of your 2016 adjustments to income and any additional standard deduction (see Pub. 505) 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2016 Form W-4* worksheet in Pub. 505.) . . . . . 5 $

6 Enter an estimate of your 2016 nonwage income (such as dividends or interest) . . . . . 6 $

7 **Subtract** line 6 from line 5. If zero or less, enter "-0-" . . . . . 7 $

8 **Divide** the amount on line 7 by $4,050 and enter the result here. Drop any fraction 8

9 Enter the number from the **Personal Allowances Worksheet,** line H, page 1 9

10 **Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1 10

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

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

1 Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**) 1

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3" 2

3 If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet 3

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

4 Enter the number from line 2 of this worksheet 4

5 Enter the number from line 1 of this worksheet 5

6 **Subtract** line 5 from line 4 6

7 Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here . . . . 7 $

8 **Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed . . 8 $

9 Divide line 8 by the number of pay periods remaining in 2016. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2016. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck 9 $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $9,000	0
6,001 - 14,000	1	9,001 - 17,000	1
14,001 - 25,000	2	17,001 - 26,000	2
25,001 - 27,000	3	26,001 - 34,000	3
27,001 - 35,000	4	34,001 - 44,000	4
35,001 - 44,000	5	44,001 - 75,000	5
44,001 - 55,000	6	75,001 - 85,000	6
55,001 - 65,000	7	85,001 - 110,000	7
65,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

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

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

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

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

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

AR4EC

STATE OF ARKANSAS
Employee's Withholding Exemption Certificate

Print Full Name _____ Social Security Number _____

Print Home Address _____ City _____ State ____ Zip _____

	How to Claim Your Withholding *See instructions below*	Number of Exemptions Claimed
Employee: File this form with your employer. Otherwise, your employer must withhold state income tax from your wages without exemptions or dependents. **Employer:** Keep this certificate with your records.	1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED ☐ You claim yourself. *(Enter one exemption)* ..... 1a ☐ You claim yourself and your spouse. *(Enter two exemptions)* ..... 1b ☐ Head of Household, and you claim yourself. *(Enter two exemptions)* 1c	
	2. NUMBER OF CHILDREN or DEPENDENTS. *(Enter one exemption per dependent)* 2	
	3. TOTAL EXEMPTIONS. *(Add Lines 1a, b, c, and 2)* If no exemptions or dependents are claimed, enter zero. 3	
	4. Additional amount, if any, you want deducted from each paycheck. *(Enter dollar amount)* 4	
	5. I qualify for the low income tax rates. *(See below for details)* ..... 5 Please check filing status: ☐ Single ☐ Married Filing Jointly ☐ Head of Household	☐ Yes ☐ No

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

Signature: _____ Date: _____

Instructions for completing the Employee's Withholding Exemption Certificate

TYPES OF INCOME - This form can be used for withholding on all types of income, including pensions and annuities.

NUMBER OF EXEMPTIONS – *(Husband and/or Wife)* Do not claim more than the correct number of exemptions. However, if you expect to owe more income tax for the year, you may increase your withholding by claiming a smaller number of exemptions and/or dependents, or you may enter into an agreement with your employer to have additional amounts withheld. This is especially important if you have more than one employer, or if both husband and wife are employed.

DEPENDENTS – To qualify as your dependent *(line 2 of form)*, a person must *(a)* receive more than 1/2 of their support from you for the year, *(b)* not be claimed as a dependent by such person's spouse, *(c)* be a citizen or resident of the United States, and *(d)* have your home as their principle residence and be a member of your household for the entire year or be related to you as follows: son, daughter, grandchild, stepson, stepdaughter, son-in-law or daughter-in-law; your father, mother, grandparent, stepfather, stepmother, father-in-law or mother-in-law; your brother, sister, stepbrother, stepsister, half brother, half sister, brother-in-law or sister-in-law; your uncle, aunt, nephew or niece *(but only if related by blood)*.

CHANGES IN EXEMPTIONS OR DEPENDENTS – You may file a new certificate at any time if the number of exemptions or dependents INCREASES. You must file a new certificate within 10 days if the number of exemptions or dependents previously claimed by you DECREASES for any of the following reasons:

(a) Your spouse for whom you have been claiming an exemption is divorced or legally separated from you, or claims his or her own exemption on a separate certificate, **or**

(b) The support you provide to a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year.

OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, does not affect your withholding until next year, but requires the filing of a new certificate by December 1 of the year in which they occur.

Claim additional amounts of withholding tax if desired. This will apply most often when you have income other than wages.

You qualify for the low income tax rates if your total income from all sources is:

(a)	Single	$10,201	to	$13,500
(b)	Married Filing Jointly (1 or less dependents)	$17,201	to	$21,400
(c)	Married Filing Jointly (2 or more dependents)	$20,701	to	$26,700
(d)	Head of Household/ Qualifying Widow(er)	$14,501	to	$19,000

For additional information consult your employer or:

Arkansas Individual Income Tax Section
Withholding Branch
P. O. Box 8055
Little Rock, Arkansas 72203-8055

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation (Employee 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

For aliens authorized to work, provide your Alien Registration Number/USCIS Number OR Form I-94 Admission Number:

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date (*mm/dd/yyyy*):

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.)

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

Signature of Preparer or Translator:	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

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 examine one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title: DRIVER'S LICENSE/OTHER		Document Title: SOCIAL SECURITY/OTHER
Issuing Authority:		Issuing Authority: ARKANSAS		Issuing Authority: UNITED STATES
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):				

2-D Barcode
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	Date (mm/dd/yyyy)	Title of Employer or Authorized Representative
		HR COMPLIANCE SPECIALIST

Last Name (Family Name)	First Name (Given Name)	Employer's Business or Organization Name
ANTHONY	TIFFANY	UNITED CEREBRAL PALSY

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	Zip Code
9720 N. RODNEY PARHAM	LITTLE ROCK	AR	72227

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

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

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date (mm/dd/yyyy):	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

EMPLOYEE ENROLLMENT FORM - LIFE INSURANCE - UNITED CEREBRAL PALSY

SOCIAL SECURITY #			Proposed effective date: ____/____/____
Please print clearly and fill in each applicable question.			
Company Name: UNITED CEREBRAL PALSY	Company City: LITTLE ROCK	State: AR	GROUP NUMBER

Enrollment Information

LAST NAME:	FIRST NAME:	MIDDLE NAME:
ADDRESS:		
CITY:	STATE: ZIP:	TELEPHONE: ( )
GENDER: ☐ MALE ☐ FEMALE	DATE OF BIRTH ____/____/____	DATE OF HIRE: ____/____/____
HOURS WORKED PER WEEK:	DATE OF FULL TIME HIRE: ____/____/____	

AGREEMENT:

I understand, agree, and represent:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage, or insurability, alter any contract, or waive any of the agency's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by the agency on the certificate of coverage/certificate of insurance.
- Any misrepresentation contained herein relied on by the agency may be used to reduce or deny a claim or void the contact within the contestable period if such misrepresentation materially affected the acceptance of the risk.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit knowingly presents information in an application of insurance is guilty of a crime and may be subject to fines and confinement in prison.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contact(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any upon written notice unless I have chosen to use pretax deductions.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issue.

Authorization

My dependents and I authorize any physician, medical, or health care practitioner, hospital, clinic veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, the Medical Information Bureau, Inc, employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and copies of all hospital or medical records, non-public personal health information, and any other non-medical information to share any and all such information with the agency, its reinsurer or its legal representatives, and its affiliates.

My dependents and I understand and agree:

- The information obtained by use of this authorization may be used by the agency to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
- If you decide not to sign this authorization, can not complete your plan enrollment or determine your premium rate due to the inability to obtain the necessary information.
- Any information obtained will not be released by the agency to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc, or other persons or organizations performing health care operations or business or legal services in connection with an application claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- Once personal and health (including medical, dental, and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
- A copy of this authorization is available to me or my legal representation upon written request.
- A photographic copy of this authorization shall be as valid as the original.
- I have the right to revoke this authorization at any time:
  - To revoke this authorization, I must do so in writing and send my written revocation to the agency's Privacy Office.
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation will become effective after it is received by The agency's Privacy Office.

SIGNATURE - please sign below if enrolling or waiving group coverage

Employee or legal representation signature: X _____ Date: X _____

Name and relationship of legal representation: _____

UCP
Understanding Disabilities
Creating Opportunities

Life Insurance Beneficiary Card

If you are married, your spouse is automatically your beneficiary.
All beneficiaries MUST be 18 years or older.

Insured's Name (Employee)	Birth Date	Social Security Number

Beneficiary	% of Benefit	Social Security Number (Optional)	Relationship
PRIMARY			Is this person over 18 years of age? Yes No
Beneficiary	**% of Benefit**	**Social Security Number (Optional)**	**Relationship**
PRIMARY SECONDARY			Is this person over 18 years of age? Yes No
Beneficiary	**% of Benefit**	**Social Security Number (Optional)**	**Relationship**
PRIMARY SECONDARY			Is this person over 18 years of age? Yes No
Beneficiary	**% of Benefit**	**Social Security Number (Optional)**	**Relationship**
PRIMARY SECONDARY			Is this person over 18 years of age? Yes No

Employee's signature _____ DATE _____

Insurer's Signature (UCP Representative) _____ DATE _____