



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 (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 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):

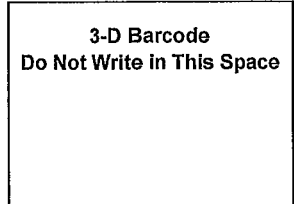
- A citizen of the United States
- A noncitizen national of the United States (See instructions)
- A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. (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)

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



Employer Completes Next Page



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 a combination of 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 following information: document 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:		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:		<div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>3-D Barcode Do Not Write in This Space</p> </div>		
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date (if any)(mm/dd/yyyy):				

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	
Last Name (Family Name)		First Name (Given Name)	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) Last Name (Family Name) First Name (Given Name)		Middle Initial	B. Date of Rehire (if applicable) (mm/dd/yyyy):
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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):
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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:
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Employee's Withholding Allowance Certificate

IT-2104

New York State • New York City • Yonkers

First name and middle initial	Last name	Your social security number
Permanent home address (number and street or rural route)		Apartment number
City, village, or post office		State ZIP code
Single or Head of household <input type="checkbox"/> Married <input type="checkbox"/> Married, but withhold at higher single rate <input type="checkbox"/> Note: If married but legally separated, mark an X in the Single or Head of household box.		
Are you a resident of New York City? Yes <input type="checkbox"/> No <input type="checkbox"/> Are you a resident of Yonkers? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Complete the worksheet on page 3 before making any entries.		
1 Total number of allowances you are claiming for New York State and Yonkers, if applicable (from line 17)		1
2 Total number of allowances for New York City (from line 28)		2
Use lines 3, 4, and 5 below to have additional withholding per pay period under special agreement with your employer.		
3 New York State amount		3
4 New York City amount		4
5 Yonkers amount		5

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Employee's signature	Date
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Penalty – A penalty of \$500 may be imposed for any false statement you make that decreases the amount of money you have withheld from your wages. You may also be subject to criminal penalties.

Employee: detach this page and give it to your employer; keep a copy for your records.

Employer: Keep this certificate with your records.

Mark an **X** in box A and/or box B to indicate why you are sending a copy of this form to New York State (see instructions):

A Employee claimed more than 14 exemption allowances for NYS A

B Employee is a new hire or a rehire ... B First date employee performed services for pay (mm-dd-yyyy) (see instr.):

Are dependent health insurance benefits available for this employee? Yes No

If Yes, enter the date the employee qualifies (mm-dd-yyyy):

Employer's name and address (Employer: complete this section only if you are sending a copy of this form to the NYS Tax Department.)	Employer identification number
--	--------------------------------

Instructions

Changes effective for 2016

Form IT-2104 has been revised for tax year 2016. The worksheet on page 3 and the charts beginning on page 4, used to compute withholding allowances or to enter an additional dollar amount on line(s) 3, 4, or 5, have been revised. If you previously filed a Form IT-2104 and used the worksheet or charts, you should complete a new 2016 Form IT-2104 and give it to your employer.

Who should file this form

This certificate, Form IT-2104, is completed by an employee and given to the employer to instruct the employer how much New York State (and New York City and Yonkers) tax to withhold from the employee's pay. The more allowances claimed, the lower the amount of tax withheld.

If you do not file Form IT-2104, your employer may use the same number of allowances you claimed on federal Form W-4. Due to differences in tax law, this may result in the wrong amount of tax withheld for New York State, New York City, and Yonkers. Complete Form IT-2104 each year and file it with your employer if the number of allowances you may claim

is different from federal Form W-4 or has changed. Common reasons for completing a new Form IT-2104 each year include the following:

- You started a new job.
- You are no longer a dependent.
- Your individual circumstances may have changed (for example, you were married or have an additional child).
- You moved into or out of NYC or Yonkers.
- You itemize your deductions on your personal income tax return.
- You claim allowances for New York State credits.
- You owed tax or received a large refund when you filed your personal income tax return for the past year.
- Your wages have increased and you expect to earn \$106,950 or more during the tax year.
- The total income of you and your spouse has increased to \$106,950 or more for the tax year.
- You have significantly more or less income from other sources or from another job.
- You no longer qualify for exemption from withholding.



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).

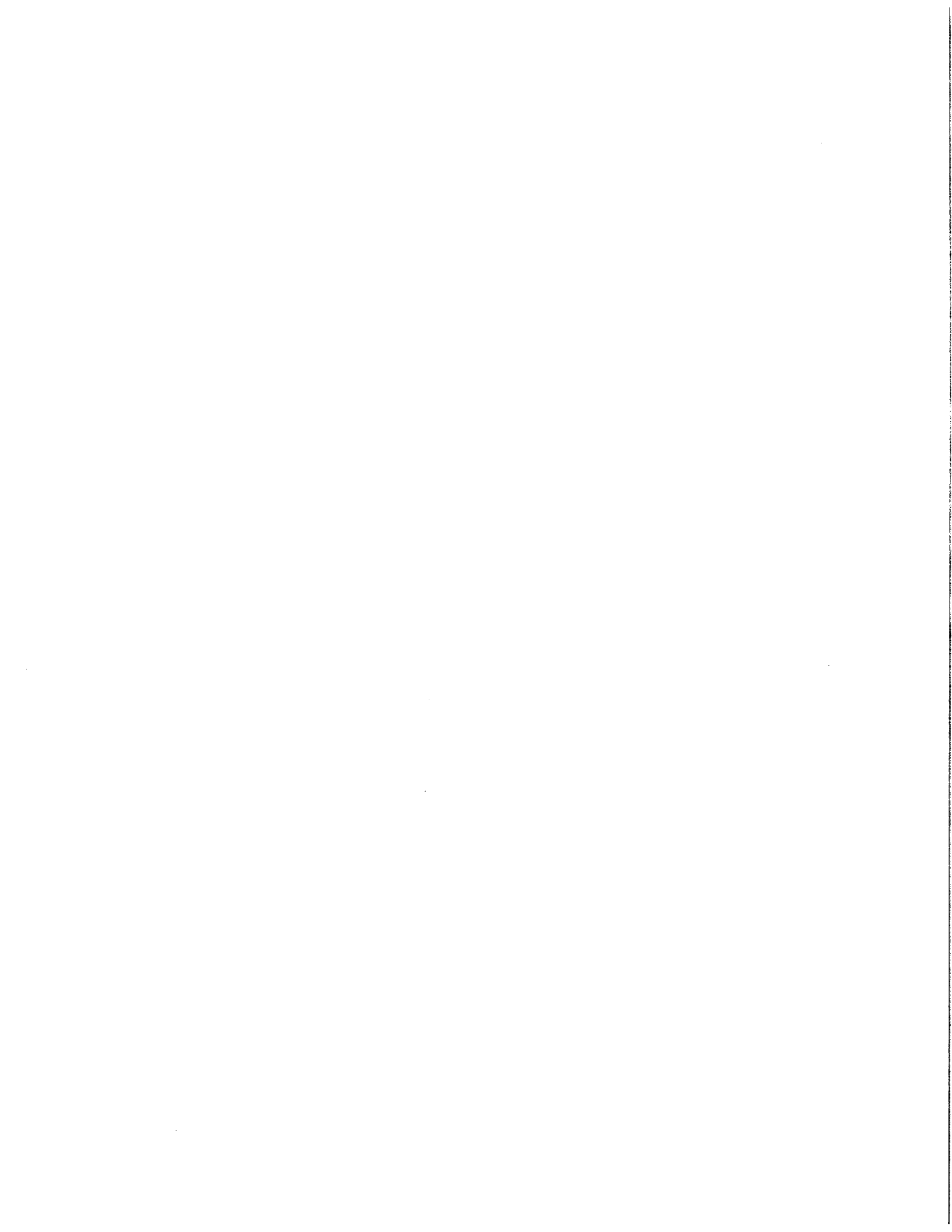
Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself if no one else can claim you as a dependent	A	<u> </u>			
B	Enter "1" if: <table border="0" style="display: inline-table; vertical-align: middle;"> <tr> <td style="font-size: 3em; vertical-align: middle;">{</td> <td style="padding: 0 10px;"> <ul style="list-style-type: none"> • 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. </td> <td style="font-size: 3em; vertical-align: middle;">}</td> </tr> </table>	{	<ul style="list-style-type: none"> • 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	<u> </u>
{	<ul style="list-style-type: none"> • 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. 	}				
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	<u> </u>			
D	Enter number of dependents (other than your spouse or yourself) you will claim on your tax return	D	<u> </u>			
E	Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above)	E	<u> </u>			
F	Enter "1" if you have at least \$2,000 of child or dependent care expenses for which you plan to claim a credit	F	<u> </u>			
(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)						
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	<u> </u>			
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	<u> </u>			
<table border="0" style="width: 100%;"> <tr> <td style="width: 15%; vertical-align: top;">For accuracy, complete all worksheets that apply.</td> <td style="width: 85%; vertical-align: top;"> <ul style="list-style-type: none"> • 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. </td> </tr> </table>				For accuracy, complete all worksheets that apply.	<ul style="list-style-type: none"> • 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. 	
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----- 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	<h2 style="margin: 0;">Employee's Withholding Allowance Certificate</h2> <p style="margin: 0;">▶ 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.</p>	OMB No. 1545-0074 2016				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">1 Your first name and middle initial</td> <td style="width: 50%; padding: 2px;">Last name</td> </tr> <tr> <td colspan="2" style="padding: 2px;">2 Your social security number</td> </tr> </table>		1 Your first name and middle initial	Last name	2 Your social security number		
1 Your first name and middle initial	Last name					
2 Your social security number						
Home address (number and street or rural route)		3 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> 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. ▶ <input type="checkbox"/>				
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)		5 <u> </u>				
6 Additional amount, if any, you want withheld from each paycheck		6 \$ <u> </u>				
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 ▶ <u> </u>						
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)				





DUNKIRK CITY SCHOOL DISTRICT

620 Marauder Drive
Dunkirk, New York 14048
Telephone (716) 366-9300

MR. KENNETH KOZLOWSKI

President
Board of Education

MR. GARY CERNE

Superintendent

OATH OF ALLEGIANCE

"I do hereby pledge and declare that I will support the Constitution of the State of New York and that I will faithfully discharge the duties of the position of ... _____ according to the best of my ability."

DATE

Employee's Name

Employee's Address





DUNKIRK CITY SCHOOL DISTRICT

620 Marauder Drive
Dunkirk, New York 14048
Telephone (716) 366-9300

MR. KENNETH KOZLOWSKI
President
Board of Education

MR. GARY CERNE
Superintendent

NAME: _____
(P.T. Instructional Employee)

SUBJECT: Retirement Membership Option

I hereby acknowledge that I have been informed by the Dunkirk City School District, that as a 'teacher/instructor' not currently a member of the NYS Teachers' Retirement System who is or will be rendering less than full-time service for the current school year, I may, as a matter of right, join the NYSTRS.

I must complete a Retirement Membership application which must be filed with the NYSTRS in order to be effective.

I understand if I do elect to join, I will be required to contribute, pursuant to Article 15 of the RSSL, 3.5% of my salary to the Retirement System.

Please acknowledge receipt of this form by indicating your option below.

Electing 'No' at this time does not prevent you from joining later.

_____ I **Do** elect the Retirement Option.

_____ I **Do Not** elect the Retirement Option.

Signature

Date





NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395

OFFICE SERVICES ONLY

APPLICATION FOR MEMBERSHIP

Please Provide All Requested Information

PART 1 - TO BE COMPLETED BY APPLICANT

Social Security Number

- -

First Name

MI

Last Name

Street Address

Street Address

City

State

Zip Code

-

Phone Number

() -

Gender

Male

Female

Date of Birth

/

/

Month

Day

Year

Marital Status (optional)

Married

Single

Former Name

Last Name

Title (Required): _____

NYSUT Affiliated Position: Yes No

PART 2 - TO BE COMPLETED BY EMPLOYER (Refer to Section 1 of the NYSTRS Employer Manual of www.nysr.org)

Mandatory Membership

1 First date of full-time service / /

Month Day Year

OR

Optional Membership

2 The earlier of:

First day of service, during or after the month in which both service was rendered and the application was notarized. (Service can be rendered after the month of notarization.)

Month Day Year

OR

First date of service for which deductions began (not payroll date).

Month Day Year

LOCATION CODE

DISTRICT NAME

PROJECTED EARNINGS 7/1-6/30
CURRENT YEAR

PROJECTED EARNINGS 7/1-6/30
NEXT YEAR

SIGNATURE OF AUTHORIZED OFFICIAL



PART 3 — TO BE COMPLETED BY APPLICANT

NYSTRS SERVICE CREDIT

* SIX IMPORTANT QUESTIONS *

As a member, you are responsible for ensuring your records are complete and accurate. Failure to provide any of the following necessary information could result in the loss of or reduction in a future benefit.

For an explanation of questions 1-5, see page 5.

1. Are you now a member of another New York State (NYS) or New York City (NYC) public retirement system? YES NO

Name of Retirement System:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2. Are you receiving a pension (monthly benefit) from another NYS or NYC public retirement system? YES NO

Name of Retirement System:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Retirement Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3. If you have former membership service that qualifies you to be reinstated, do you elect reinstatement? *This election is irrevocable.* YES NO

If yes, in what system was your former service credited:

Name of Retirement System:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

System Membership or Registration #:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4. Do you wish to claim previous NYS or NYC public employment or public teaching service not included in question 3? YES NO

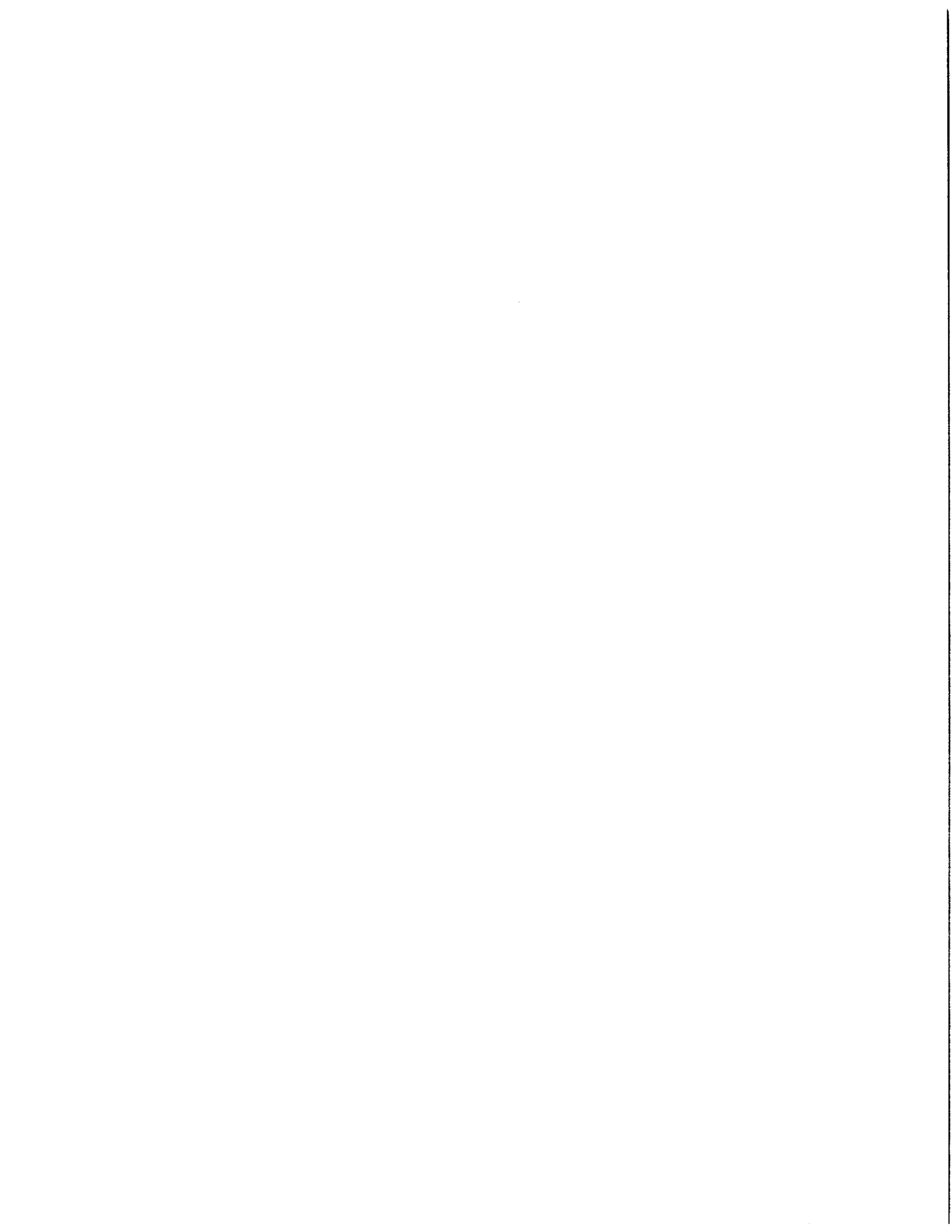
5. Have you ever served in the armed forces of the United States? YES NO

6. Are you currently rendering service at a NYS University or Community College under the Optional Retirement Program? YES NO

If yes, name the college:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--





Member Social Security Number

Grid for Member Social Security Number

Name and Address of Beneficiary(ies)

Check One: Primary Contingent

First Name, MI, Last Name grid

Street Address grid

Street Address grid

City, State, Zip Code grid

Date of Birth, Male/Female, Beneficiary Social Security Number, Relationship grid

I understand my designated beneficiary(ies) will receive the death benefit coverage authorized by Paragraph 2 of Section 606(a) of the Retirement and Social Security Law.

I direct the New York State Teachers' Retirement System, in the event of my death prior to retirement, to pay the death benefit and my contributions in one payment to the beneficiary(ies) listed above. If more than one beneficiary is listed, the share of any beneficiary who predeceases me will be equally shared by the surviving beneficiary(ies). I further direct that if I survive all designated primary beneficiaries, the benefit shall be paid in equal shares to the surviving contingent beneficiary(ies). If I should survive all designated beneficiaries, the amount of any death benefit shall be paid to my estate.

A portion of the death benefit coverage under Paragraph 2 Section 606(a) of the Retirement and Social Security Law may continue into retirement. The individuals listed above or on the most recently filed Designation of Beneficiary form are the beneficiary(ies) for this coverage.

I certify that the information I provide on this application is correct. I understand that I must contribute between 3% to 6%, based on my earnings, if my death occurs prior to retirement or the termination of my membership, those contributions, with interest, will be paid to my designated beneficiary(ies) or my estate.

By filing this application, I claim any prior service for which I am eligible. I also understand that my address may be updated based on the submission of payroll data by my employer.

This application must be signed and notarized in order to be valid.

Signature of Applicant and Married women must use their given name (Mary Smith not Mrs. John Smith)

Notary Public section: State of, County of, On this day of in the year before me, the undersigned, a Notary Public in and for said State, personally appeared personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument, and acknowledged to me that he/she executed the same in his/her capacity, and that by his/her signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Signature of Notary: Expiration Date:





OMNI USE ONLY

School #	
Rec.	
Initials	
Comp	

Employee Contributions Only*

403(b) 457 Roth 403(b) [please pick one]

**Salary Reduction Agreement ("SRA")
For Tax Sheltered Annuities and Custodial Accounts**

IMPORTANT NOTICE

Before you sign, please read all information on this form: (Note: ALL employees are eligible to participate in a 403(b) Plan. A Tax Sheltered Annuity ("TSA") is an investment account that is set aside for your retirement (only), and is paid for with "pre-tax" dollars. A Custodial Account ("CA") is the group or individual custodial account or accounts, established for each Employee, by the Employer, or by each Employee individually, to hold assets of the Plan. Unless utilizing the catch-up provisions, your Maximum Allowable Contribution ("MAC") cannot exceed \$15,500 (\$20,500 if age 50 or over). Both TSA & CA receive tax deferred treatment.

Part 1: Employee Information - Mandatory. Please Print Clearly to Ensure Timely Processing.		
Social Security Number:	School District Name: Select One: <input type="checkbox"/> New Hire <input type="checkbox"/> Existing ("Employer")	
Your Name:	Date of Birth:	Date of Hire:

Part 2: Employer Information - To Be Completed by Payroll Office, if Applicable		
Salary:	# of TSA/CA Pay Periods:	Effective Payroll Date:
Signature & Date:		Employer Name & Title:

Part 3: Contribution Information - Mandatory. Please review and select the applicable option(s).				
<input type="checkbox"/>	I do not wish to participate at this time. I understand that I may participate in the program at any time in the future by contacting a district participating service provider (An investment company who has signed an Information Sharing Agreement with OMNI). STOP: Please proceed to Part 5 and return agreement to Employer.			
<input type="checkbox"/>	Discontinue SRA(s). Please discontinue my salary reduction(s) indicated below:			
	Service Provider Name:	Effective Payroll Date:		
<input type="checkbox"/>	No change. I am a current TSA/CA participant; continue my existing SRA and Service Provider			
<input type="checkbox"/>	Initiate a New salary reduction. Please indicate the Service Provider(s) and amounts in the table below. You must establish your account with a participating Service Provider prior to submitting this request.			
<input type="checkbox"/>	Change a Current Salary Reduction Amount or Provider. Please indicate the Service Providers/Amounts in the table below. If you are changing Employers, you must also notify your participating Service Provider(s) of the change prior to submitting this request.			
<input type="checkbox"/>	Special Contribution Request. Please indicate the Service Providers/Amounts in the table below.			
	Please select:			
	<input type="checkbox"/> Final Contribution, no further deductions.			
	<input type="checkbox"/> One Time Contribution, prior reductions will resume in the following payroll.			
	Service Provider Name:	Account # (if known):	Amount [†] Per Pay Period:	Effective Payroll Date [‡] :

* Form may not be used for Employer or Non-Elective Contributions, please contact your Employer for these requests.

† If a percentage of salary is indicated, please contact your Employer as they may need to complete Part 2 prior to submission to OMNI.

‡ Requested Payroll Effective Date: Salary reduction instructions shall be implemented in accordance with your Employer's next available payroll schedule, unless otherwise indicated. We are unable to process retroactive requests.

Part 4: Agreements and Acknowledgements

The above named Employee where applicable, agrees as follows:

1. To modify his/her salary reduction as indicated above.
2. That his/her Employer transfers the above stated funds on Employee's behalf to OMNI for remittance to the selected Service Provider(s).
3. This SRA is legally binding and irrevocable with respect to amounts paid.
4. This SRA may be changed with respect to amounts not yet paid.
5. This SRA may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new SRA is submitted.
6. (a) That OMNI does not choose the annuity contract or custodial account in which your contributions are invested.
 (b) OMNI does not endorse any authorized Service Provider, nor is it responsible for any investments.
 (c) OMNI makes no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the TSA and/or CA described herein.
 (d) OMNI shall not have any liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the TSA and/or CA, its terms, the selection of the insurance company or regulated investment company, the financial condition, operation of or benefits provided by said insurance company or regulated investment company, or his/her selection and purchase of shares of regulated investment companies. Nothing herein shall affect the terms of employment between Employer and Employee.
7. To be responsible for setting up and signing the legal documents necessary to establish a TSA or CA.
8. To be responsible for naming a death beneficiary under their TSA or CA. This is normally done at the time the contract or account is established. Beneficiary designations should be reviewed periodically.
9. When provided all required information in a timely manner, OMNI is responsible for determining that salary reductions do not exceed the allowable contribution limits under applicable law, and will complete MAC calculations as required by law.
10. To contact OMNI to start the process on any requests for loans, hardship withdrawals, account exchanges or plan-to-plan transfers.
11. This SRA is subject to the terms of the Services Agreement between OMNI and Employer, and to the Information Sharing Agreement between OMNI and the Service Providers, copies of which may be obtained from Employer.
12. This agreement supersedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Part 5: Employee Signature (Mandatory)

I certify that I have read this complete agreement and that my salary reductions do not exceed contribution limits as determined by applicable law. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the TSA or CA established by me under the Plan are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature: _____ Date: _____

Part 6: Acknowledgment and Representation of Sales Agent/Representative (If Applicable)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. A calculation of maximum allowance will be provided annually for Employee contributing more than \$15,500 (\$20,500 if over 50) or utilizing the "catch-up provisions". Furthermore, my employer (name) _____ agrees to indemnify and hold harmless the Employer, any individual member of the governing board and the Employee participating in the 403(b) Program against any claims based on an error in the MAC I provided, except where the error is based upon erroneous information provided by Employer or Employee. Additionally, I will notify OMNI regarding any distributions or loan to participants.

Sales Agent/Representative Name: _____ (Please Print) Phone _____

Address: _____

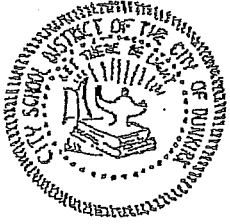
Signature: _____ Date: _____

Our employees are committed to prompt and accurate processing for our customers. By filling out this agreement completely, you will assist us in meeting our goal of processing your request in a timely manner.

Please return this agreement to The OMNI Group, unless otherwise advised by your Employer:

The OMNI Group
Watertown Office Park • 1099 Jay Street, Building F • Rochester, NY 14611
Toll Free: (877) 544-OMNI • Fax: (585) 436-3633

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DUNKIRK CITY SCHOOL DISTRICT

620 Marauder Drive
Dunkirk, New York 14048
Telephone (716) 366-9380
Fax (716) 366-9399

MR. KENNETH A. KOZLOWSKI

President
Board of Education

MR. GARY CERNE
Superintendent

New employee....

As a 10 month employee on salary, you have the choice of dividing your contract salary between 22 or 26 paychecks.

Circle one.

Payroll Office

Example: 22,000 - 22 = 1,000.00
 22,000 - 26 = 807.69

With 26 pays, you receive 4 additional pays in the last week of June.

This is especially nice to cover your expenses, remodeling or vacation plans in July and August.



Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Dunkirk City School District to initiate automatic deposits to my account at the financial institution named below. I also authorize Dunkirk City School District to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Dunkirk City School District responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Dunkirk City School District receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

If you close your account, notify our office immediately. Failure to do so, may result in a delay in getting your money returned to the school and the reissue of a new check.

Attach a voided check here:

100%

Dollar Amount: \$ _____

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____

Checking | Savings

Authorized Signature: _____

Date: _____

Payroll Clerk Signature: _____

Eff. _____

Date _____

