



Non-Benefited to Benefited Pre-Employment Paperwork

ePAF#

All employees appointed to benefited positions from non-benefited positions at the University must complete the attached pre-employment paperwork within two weeks of receipt in order to ensure the University's payroll system reflects the new position by their start date. Return all properly completed forms to the Office of Human Resources, Third Floor Quinn Administration Building.

Completed by appointee:

1. **University of Massachusetts Boston, Self-Identification Form**
It is the policy of the University of Massachusetts to collect, maintain, and report certain ethnicity, race, disability, and Vietnam Era Veteran status information as required by federal and state entities. Completion of any part of this form is strictly voluntary but will enable the University to accurately report the diversity of its faculty and staff and to monitor the effectiveness of its affirmative action programs. Any data collected as part of this process will not be used to make employment-related decisions. The University's policy on the collection, maintenance, and reporting of such information is available at: www.umb.edu/odei
2. **Voluntary Self-Identification of Disability**
Completion of any part of this form is strictly voluntary but will enable the University to accurately report the diversity of its faculty and staff and to monitor the effectiveness of its affirmative action programs. Any data collected as part of this process will not be used to make employment-related decisions. The University's policy on the collection, maintenance, and reporting of such information is available at: www.umb.edu/odei
3. **State Board of Retirement New Member Enrollment Form**
All active state employees are required to contribute a percentage of their salary towards their retirement. This contribution is deposited into an annuity account on behalf of the member. A statement of the annuity account balance is mailed to all active members yearly. Refer to www.mass.gov/treasury/retirement/state-board-of-retire for information.
4. **Statement Concerning Your Employment in a Job Not Covered by Social Security (Form SSA –1945)**
You must sign and date this form, which explains how a pension from this new position could affect future Social Security benefits to which you may become entitled (as per the Social Security Protection Act of 2004)
5. **Background Check - Written Notice of Acknowledgement Form**
Please note that this offer of employment is specifically conditioned upon you consenting to and successfully completing a background review satisfactory to the University of Massachusetts, including a criminal background check, CORI check and sex offender check, verification of employment history and academic credentials.
6. **Resume**
As part of the university's comprehensive background check process, prospective employees are requested to provide information regarding their employment and educational history. To ensure that the background check is inclusive of employee's credentials, a current resume/CV is required.

All state and federal tax reporting, direct deposit, mailing address, and emergency contact information currently in the university's payroll system will not change, unless you would like to do so. Changes to this information can be made now or at any time during your active employment at the university through HRDirect Self Service which can be found on the Human Resources website: <https://hr.umb.edu/> Click on HRDirect → Main Menu → Self Service.

Please indicate your acceptance of this change to benefitted status by signing below and returning to Department of Human Resources at the University of Massachusetts Boston, 100 Morrissey Boulevard, Boston, MA 02125:

I understand and acknowledge that by signing below, I agree that this offer, consisting of the terms stated in this letter, constitutes the entire agreement between the University and myself. In addition, I understand that all staff members are employed pursuant to and subject to the policies, rules and regulations adopted by the Board of Trustees as amended, revised, or repealed from time to time, under the provisions of Chapter 75 of the General Laws, as amended or revised from time to time. By accepting this conditional job offer, I attest that the information provided to the University during the selection process is true and accurate to the best of my knowledge and that I understand that falsification of any such information—whenever it is discovered—could result in discipline up to and including discharge

(Appointee) Print Name

Date:

(Appointee) Signature

Date:



University of Massachusetts Boston - ODEI Self-Identification Form

The University of Massachusetts Boston is an equal opportunity employer and is required by law to periodically collect and report certain data (including data on citizenship, gender and race/ethnicity, as well as disability and veteran status) regarding our faculty and staff. The information collected via this form will be entered in the University of Massachusetts Boston’s Human Resources’ information system and may be used in accordance with the applicable laws and regulations concerning equal employment opportunity.

Instructions: New hires and re-hires, please complete this form in its entirety. Current employees requesting changes, please complete all of Sections I and II and only the information you wish to update on Section III. Upon completion please return this form to the Office of Diversity, Equity and Inclusion (ODEI.) This Form will be filed separately from your personnel file.

Section I: Name and Status

Select One: New Hire/Rehire - Start Date or Effective Date of Change: _____
 Current Employee - ID#: _____

Name: _____
(Last, First, Middle)

Section II: Department and Position Information

Department: _____

Position Title: _____

Position Classification: Faculty Professional Classified

Section III: Personal Information and Self-Identification (Completion of the following information is voluntary.)

Sex: Female Male

Race/Ethnicity (Please provide both):

1. Hispanic Ethnicity: Hispanic or Latino Not Hispanic or Latino

2. Racial Identity: (Please select one or more of the following racial categories)

- American Indian or Alaska Native Asian
- Black or African American White
- Native Hawaiian or Other Pacific Islander

Military Status (Select one): No Protected Military Service Active Duty or Wartime or Camp Badge
 Armed Forces Service Medal Veteran Recently Separated Veteran
 National Guard/Reserves

Disability Status: Individual with a Disability I Do Not Have a Disability
 Disabled Veteran

NOTE: For accommodations, please contact the Office of Diversity, Equity and Inclusion at 617.287.4818.

Section IV: Signature and Date

SIGNATURE: _____ **Date:** _____ I do not wish to self-Identify.

SELF-IDENTIFICATION DEFINITIONS: Completion of this information is voluntary. All information is confidential and will be reported in aggregate form only. Declining to provide this information will not subject you to any adverse treatment.

Ethnicity and Race – This two-part question is requested for statistical reporting purposes to government agencies, including the U.S. Department of Education.

- **Hispanic Ethnicity-** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin (including Spain) regardless of race.
- **American Indian or Alaska Native -** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- **Asian -** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American -** A person having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander -** A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White -** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

MILITARY STATUS AND DISABILITY STATUS SELF-IDENTIFICATION

- This information is requested for statistical reporting purposes to government agencies, including the U.S. Department of Labor. Completion of this information is voluntary. All information is confidential and will be reported in statistical form only. Declining to provide this information will not subject you to any adverse treatment. Information regarding your disability may be disclosed to the extent that (1) your supervisor(s) may be informed of any work restrictions or reasonable accommodations needed, and (2) first aid personnel may be informed when and if you require emergency medical treatment. Protected Veteran Categories:
- A **Disabled Veteran** is one of the following:
 - a. A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
 - b. A person who was discharged or released from active duty because of a service connected disability.
- **A Recently Separated Veteran:** Any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground naval or air service.
- **An Active Duty Wartime or Campaign Badge Veteran:** A veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- **An Armed Forces Service Medal Veteran:** A veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces Service Medal was awarded pursuant to Executive Order 12985
- **Military Discharge Date:** The date on which a person was discharged or released from military service.

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020
Page 1 of 2

Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.¹ To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Autism
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Deafness
- Cerebral palsy
- Major depression
- Obsessive compulsive disorder
- Cancer
- HIV/AIDS
- Multiple sclerosis (MS)
- Impairments requiring the use of a wheelchair
- Diabetes
- Schizophrenia
- Missing limbs or partially missing limbs
- Intellectual disability (previously called mental retardation)
- Epilepsy
- Muscular dystrophy

Please check one of the boxes below:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

Your Name

Today's Date

Voluntary Self-Identification of Disability

Form CC-305
OMB Control Number 1250-0005
Expires 1/31/2020
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Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

ⁱ Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.



THE COMMONWEALTH OF MASSACHUSETTS
State Board of Retirement
 ONE WINTER STREET, 8TH FLOOR, BOSTON, MA 02108

**COMMONWEALTH AGENCY
 NEW MEMBER
 ENROLLMENT FORM**

SECTION A TO BE COMPLETED BY MEMBER - SECTION B TO BE COMPLETED BY AGENCY
PLEASE RETURN COMPLETED FORM TO THE MASSACHUSETTS STATE RETIREMENT BOARD

SECTION A - TO BE COMPLETED BY MEMBER

1. MEMBER INFORMATION

Name (Print)			Former Name		SSN	
Street Address			Date of Birth		Gender: M <input type="checkbox"/>	
City	State	Zip Code	Phone Number		F <input type="checkbox"/>	
E-Mail						
Marital Status:						
<input type="checkbox"/> Married		<input type="checkbox"/> Single		If Divorced , are you subject to a Qualified Domestic Relations Order?		
<input type="checkbox"/> Widowed		<input type="checkbox"/> Divorced				
Are you a Veteran?			The retirement law establishes specific periods of active service, which may qualify you for certain Veteran benefits.		Spouse Date of Birth	
<input type="checkbox"/> Yes <input type="checkbox"/> No					Spouse Name	
Dates of Military Service			Employment		Start Date	
A copy of your military discharge may be requested			Agency or Department		Agency Phone Number	

2. PAST MEMBERSHIP HISTORY WITH ANY OTHER CONTRIBUTORY RETIREMENT SYSTEM IN MASSACHUSETTS

Retirement System	Start Date	End Date	Was a Refund Taken?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you wish to reinstate / purchase past creditable service you must make a separate request to the State Retirement Board.

3. ARE YOU CURRENTLY OR HAVE YOU EVER RECEIVED A RETIREMENT ALLOWANCE FROM ANOTHER PUBLIC RETIREMENT SYSTEM? Yes No

4. STATEMENT AND SIGNATURE OF MEMBER

I certify the above information to be true and correct to the best of my knowledge and hereby accept membership in the Massachusetts State Employees' Retirement System. This statement is signed under penalties of perjury.

Member Signature _____ Date _____ *Continued on reverse*

NEW MEMBER ENROLLMENT FORM - PAGE 2

SECTION A (CONTINUED)

5. BENEFICIARY INFORMATION

Beneficiary or beneficiaries nominated will receive in the proportion designated any amount due at your death, if you pass away prior to retirement. The right to change any nominated beneficiary is reserved by the member.

A beneficiary blank with corrections or erasures is not acceptable

Give Complete Name and Address of Each Beneficiary

Name:	Designation (Must check 1 box)	Proportion* (Must check 1 box)	DOB:
Street:	<input type="checkbox"/> Primary, <u>OR</u>	<input type="checkbox"/> All, <u>OR</u>	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____% (Percent)	SSN:
Name:	Designation	Proportion*	DOB:
Street:	<input type="checkbox"/> Primary, <u>OR</u>	<input type="checkbox"/> All, <u>OR</u>	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____% (Percent)	SSN:
Name:	Designation	Proportion*	DOB:
Street:	<input type="checkbox"/> Primary, <u>OR</u>	<input type="checkbox"/> All, <u>OR</u>	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____% (Percent)	SSN:
Name:	Designation	Proportion*	DOB:
Street:	<input type="checkbox"/> Primary, <u>OR</u>	<input type="checkbox"/> All, <u>OR</u>	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____% (Percent)	SSN:

***The totals of all proportions for your primary and contingent beneficiary(ies) MUST equal 100% EACH.**

6. PLEASE SIGN BELOW

Member Signature _____

Date _____

Witness Signature _____

Witness may not be beneficiary

A Change of Beneficiary Form must be used if you wish to change your designated beneficiary(ies). You may obtain this form from the State Retirement Board or mass.gov/retirement.

SECTION B - TO BE COMPLETED BY THE AGENCY

Position: _____ Start Date: _____

State Police Start Date: _____ Date of First Deduction: _____ New Transfer

Rate to be deducted for retirement: 5% 7% 8% 9% 12%

Service Status: Full-Time Part-Time _____% Temp/Sub _____% Other _____

Authorized Signature _____

Date _____

Agency and Payroll Number _____

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

Employee Name: _____

Employee ID # _____

Employer Name: University of Massachusetts Boston

Employer ID# UMS/1271

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

Windfall Elimination Provision

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

Government Pension Offset Provision

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

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

For More Information

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

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

Signature of Employee _____ **Date** _____

Information Regarding Social Security Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security

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

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

FICA/Medicare Deduction

The Consolidated Omnibus Budget and Reconciliation Act (COBRA) which became law on April 1, 1986 mandates that all state government employees hired on or after April 1, 1986 are required to pay the Medicare portion of the Social Security tax. This tax is 1.45% of a person's annual salary. The employer is required to match the employee contribution. Regular weekly deductions will be made from the salaries of University employees subject to the Medicare deduction.

An exception to the Medicare deduction may apply to individuals who are hired by the University of Massachusetts Boston after April 1, 1986 and who are transferring from another state agency or position with continuous state service. Service at the previous state agency must have begun prior to April 1, 1986. If you feel you should be exempted from the FICA/Medicare deduction, please inform Human Resources as soon as possible.

Use of Social Security Numbers

Although the University does not deduct full social Security and does not require employee to use their social security number for identification purposes, the University reserves the right to examine an employee's social security card to verify that the name on the card matches the name being used for payroll purposes.



**UNIVERSITY of
MASSACHUSETTS
BOSTON**
Department of Human Resources
100 Morrissey Blvd.
Boston, MA 02125-3393

HR use only: Benefited

**BACKGROUND CHECK INFORMATION
WRITTEN NOTICE OF ACKNOWLEDGEMENT FORM**

As a prospective employee or a volunteer of the University of Massachusetts Boston, I understand and agree that the University will conduct a background check and a Massachusetts Criminal Offender Record Information (CORI) check. I may withdraw this authorization at any time by providing written notice to Human Resources of my intent to withdraw consent to a background check and a CORI check.

As a prospective employee or a volunteer, I understand and agree that a background check will be submitted with my personal information to the vendor contracted by the University of Massachusetts (Creative Services, Inc.) and to the Department of Criminal Justice Information Services (DCJIS) Criminal Offender Records Information (CORI). You will receive **two** separate emails with 1.) a link to the instructions on how to log in to Creative Services, Inc. and 2.) an access code which is required to login and complete the online form. These emails will come from Human Resources staff.

As a prospective employee or a volunteer, I understand and agree that an offer of employment may be extended and employment may begin, but will be contingent upon the receipt of an acceptable background check and CORI report. The background check and CORI report will be used for employment purposes and shall only be accessed for applicants who are otherwise qualified for the position for which they have applied. Unless otherwise provided by law, a criminal record will not automatically disqualify an applicant.

If an authorized official is inclined to make an adverse employment decision based on the results of a criminal history and/or other background check, I understand and agree that I will be notified immediately and shall be provided with a copy of the University's Background Check policy, as well as copy of my criminal history record (when this record is used in making an adverse employment decision). The source(s) of the criminal history will also be revealed. I will then be provided with an opportunity to dispute the accuracy of the background check and CORI record. I shall also be provided a copy of DCJIS' Information Concerning the Process for Correcting a Criminal Record. I acknowledge that the University's entire policy can be found on the Human Resources website www.hr.umb.edu.

I hereby acknowledge and provide permission to the University of Massachusetts Boston of the date that this Acknowledgement Form was signed by me to request my personal information from the background check vendor and DCJIS.

The University is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI reports for the purpose of screening prospective employees.

By signing below, I provide my consent to a Creative Services, Inc. background check and CORI check and acknowledge that the information provided to the University is true and accurate to the best of my knowledge. Falsification of any such information-whenver discovered-could result in termination.

Signature

Date

BACKGROUND CHECK REQUEST FORM

Please complete the following **REQUIRED** fields (please print clearly and legibly):

Legal Last Name

Legal First Name

MI

Suffix

Other Legal Name(s) by which you may have been known by (please include first and last name)

Date of Birth (MM/DD/YYYY)

Last 6 Digits of your SSN

Current Mailing Address

Human Resources and Creative Services, Inc. will contact you at the e-mail address used for your online application to initiate the background check process.

PLEASE RETURN THE ORIGINAL FORM, ALONG WITH YOUR PRE-EMPLOYMENT PAPERWORK TO:

**University of Massachusetts Boston
Department of Human Resources
Quinn Administration Building, 3rd Floor
100 Morrissey Boulevard
Boston, MA 02125**