Non-Benefited Employee Pre-Employment Paperwork

ePAF#

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

Section I. Completed by appointee:

1. ☐ **Personal Data Questionnaire (PDQ)**
   You must complete, sign and date the bottom of the form.

2. ☐ **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

3. ☐ **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

4. ☐ **Retirement Savings Plan (Massachusetts Deferred Compensation SMART Plan)**
   The federal government requires that every employee contribute to some form of retirement savings plan. Types of Employees who are NOT required to contribute to the SMART Plan are: participating members of the State Board of Retirement; employees retired from State service; employees age 70 or older who have elected to stop contributions to the State Retirement System; and active UMass Boston students enrolled in and regularly attending six or more credit courses. NOTE: Employees who participate in the Massachusetts Teachers' Retirement System are **NOT** exempt from paying into this plan.

5. ☐ **Mandatory Direct Deposit**
   Your payroll check will be deposited directly into your account: checking, savings, credit union, etc. The University offers the ability to have your check deposited into a combination of up to four accounts.

6. ☐ **Conflict of Interest Law Requirements**
   Annual conflict of interest law education and training is mandated by the University of Massachusetts Boston and the Commonwealth of Massachusetts.

7. ☐ **State Tax Form (M-4)**
   The appointee must complete, sign and date the bottom of the form.

8. ☐ **Federal Tax Form (W-4) ***
   The majority of the form is a worksheet for determining the appropriate number of exemptions. The appointee must complete, sign, and date the bottom half of the first page of this form. *Due to federal law mandates, Non-Resident Aliens must contact Human Resources by emailing HRDirect@umb.edu for additional information. For non-resident aliens, there may be tax implications if you do not complete and submit the form. This may result in additional withholdings and/or penalties from the Internal Revenue Service. The university will not adjust your tax forms if you do not complete them nor is the university financially responsible to refund any tax penalties.

   The University of Massachusetts Boston is not responsible for determining your withholding allowance. If you have questions on exemptions, withholdings and/or any other tax related questions please contact the Internal Revenue Service directly at www.irs.gov.

   Please note: Residents of Rhode Island must also complete the Rhode Island Federal Tax Form (W4)

9. ☐ **Massachusetts Disclosure Form**
   If applicable, complete the form by including the name(s) of family members who are currently employed by the state.

10. ☐ **Computer Awareness and Data Security Compliance Statement**
    You must sign and date the bottom of the form.

11. ☐ **Notice and Acknowledgement: Paid Family and Medical Leave Law – MGL c. 175M – 07-SEP-2019**
    You must sign and date the PFML Notice Acknowledgement form.

12. ☐ **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.

Section II. Completed by appointee and university representative:

☐ **Employment Eligibility Verification Form (Form I9) ***Please read instructions thoroughly*****

Newly hired employees must complete **Section 1** of this form no later than their first day of employment. The hiring department must complete **Section 2** of Form I9 within three (3) business days of the first day of employment after reviewing the original documents presented. An appointee must provide documents within three days of their date of hire that will verify identity as well as U.S. employment eligibility.

Section III. Received by appointee:

By signing below, appointee acknowledges receipt and understanding of the University policies listed below. The policies can be downloaded as a packet from the Forms page on the HR website: https://hr.umb.edu/policies

- **Data Security, Electronic Mail, and Computer Policy Development (Doc. T097-010)**
- **Drug-Free Workplace Policy**
- **Federal Affordable Care Act (ACA) notification/information**
- **Guide to the Conflict of Interest Law**
- **Guide to Political Activity (Public Employees and Fundraising)**
- **Massachusetts Pregnant Workers Fairness Act**
- **Non-Discrimination and Harassment Policy (Doc. T16-040)**
- **University of Massachusetts Boston Background Check Policy**
- **University of Massachusetts Policy on Fraudulent Financial Activities (Doc. T00-051)**
- **University of Massachusetts Principles of Employee Conduct (Doc T96-136)**

I have received, completed, and understand the forms and information listed above. I also understand that my name will not be added to the University's payroll until all of the appropriate paperwork is properly completed and submitted to the Office of Human Resources.

_____ _____

(Appointee) Print Name **Date**

_____

(Appointee) Signature

University representative (department) contact information:

Name:_____

Department:_____

Email:_____ Extension: _____

UNIVERSITY OF MASSACHUSETTS BOSTON
DEPARTMENT OF HUMAN RESOURCES

PERSONAL DATA QUESTIONNAIRE

Social Security Number

First Name	Middle Name	Last Name	
Street Address			Telephone
City	State/Country	Zip Code	Marital Status Single Married
Birth Date**	Place of Birth		Gender Male Female

**If you are currently age 60 or over and starting a benefited position, you will be affected by Section 5 of Chapter 32 of the M.G.L. Please bring this fact to the attention of the Benefits Office Staff when you attend the New Employee Orientation.
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIV/Chapter32/Section5

Educational Data

Educational Level	Degree	Major	School Name	Year Awarded
High School/Equivalent				
Technical Certificate				
College/University				
Master's Level Degree				
Doctorate				

EMERGENCY CONTACTS

	Name	Address	Telephone	Relationship
PRIMARY				
SECONDARY				

PRIOR SERVICE IN ANY MASSACHUSETTS GOVERNMENT AGENCY

If retired from any government agency: (CHECK)

Name of Agency	From	To

"I attest that I have read and understood all of the contents of this form and that all of the information provided on this form is correct and complete to the best of my knowledge."

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
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ Asian
☐ White

Military Status (Select one):

☐ No Protected Military Service
☐ Armed Forces Service Medal Veteran
☐ National Guard/Reserves
☐ Active Duty or Wartime or Camp Badge
☐ Recently Separated Veteran

Disability Status:

☐ Individual with a Disability
☐ Disabled Veteran
☐ I Do Not Have a Disability

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

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

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

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.

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[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.

Participant Enrollment
Governmental 457(b) Plan

Massachusetts Deferred Compensation SMART Plan - Mandatory OBRA 98966-02

Participant Information

Last Name | First Name | MI

(The name provided MUST match the name on file with Service Provider.)

Social Security Number

Mailing Address

E-Mail Address

City | State | Zip Code

◯ Married ◉ Unmarried ◯ Female ◉ Male

( ) Home Phone ( ) Work Phone

Mo Day Year Date of Birth

Mo Day Year Date of Hire

❑ Check box if you prefer to receive quarterly account statements in Spanish.

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

Important Notice: Employees participating in the Massachusetts Deferred Compensation SMART Plan - OBRA Mandatory Plan (the Plan) must complete Social Security Form SSA-1945. The Plan has been designated as an alternative retirement system for part time employees not covered by their employers retirement system. The SSA-1945 explains the potential effects of the Windfall Elimination Provision and Government Pension Offset Provision under the Social Security law which may reduce the amount of your Social Security retirement or disability benefits, and/or benefits received by you as a spouse or an ex-spouse. If you have any questions regarding SSA-1945 or if you have not completed SSA-1945, please contact your employer.

Payroll Information

Division Name

To be completed by Representative:

Division Number

Investment Option Information (applies to all contributions) - Please refer to your communication materials for information regarding each investment option.

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

INVESTMENT OPTION NAME	INVESTMENT OPTION CODE (Internal Use Only)	
SMART Capital Preservation Fund	**MELINC**	**100%**

Plan Beneficiary Designation

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

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

Primary Beneficiary

100.00%

% of Account Balance | Social Security Number | Primary Beneficiary Name | Date of Birth

( )

Phone Number *(Optional)*

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

(•) Spouse ( ) Child ( ) Parent ( ) Grandchild ( ) Sibling ( ) My Estate ( ) A Trust ( ) Other ( ) Domestic Partner

Contingent Beneficiary

100.00%

% of Account Balance | Social Security Number | Contingent Beneficiary Name | Date of Birth

( )

Phone Number *(Optional)*

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

( ) Spouse ( ) Child ( ) Parent ( ) Grandchild ( ) Sibling ( ) My Estate ( ) A Trust (•) Other ( ) Domestic Partner

Participation Agreement

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

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

Incomplete Forms - I understand that in the event my Participant Enrollment form is incomplete or is not received by Service Provider at the address below prior to the receipt of any deposits, I specifically consent to Service Provider retaining all monies received and allocating them to the default investment option.

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

Last Name	First Name	M.I.	Social Security Number	98966-02 Number

Signature(s) and Consent

Participant Consent

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

Participant Signature **Date**

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

Participant forward to Service Provider at:
Great-West Retirement Services®
P.O. Box 173764
Denver, CO 80217-3764
Phone #: 1-877-457-1900
Fax #: 1-866-745-5766
Web site: www.mass-smart.com

PARTICIPATE

OBRA Information Guide

SAVE MONEY AND RETIRE TOMORROW

Basic Facts About OBRA and the Massachusetts Deferred Compensation SMART Plan

As a part-time, seasonal or temporary employee of the Commonwealth of Massachusetts or a part-time, seasonal or temporary employee of a participating Massachusetts local government employer not eligible to participate in the employer's retirement program or not covered under a Section 218 Agreement, you are required to participate in the Massachusetts Deferred Compensation SMART Plan (SMART Plan).[1] The SMART Plan is an alternative to Social Security as permitted by the federal Omnibus Budget Reconciliation Act of 1990 (OBRA). OBRA, passed by the U.S. Congress, requires that beginning July 1, 1991, employees not eligible to participate in their employer's retirement program be placed in Social Security or another program meeting federal requirements. The SMART Plan meets those federal requirements.

Mandatory Contributions

As an OBRA employee, you must contribute at least 7.5% of your gross compensation per pay period to the SMART Plan. This contribution is deducted on a pretax basis, reducing your current taxable income. This means that you will not pay any tax on this money until it is distributed from your account.

Your human resources or payroll center representative will provide you with an OBRA Mandatory Participation Agreement. Please complete and return the form to either your human resources or payroll center representative.

Investment Option

All mandatory contributions to the SMART Plan will be invested in the SMART Capital Preservation Fund. The SMART Capital Preservation Fund is designed to help protect your principal and maximize potential earnings. Your account will earn interest based upon the prevailing rates for this type of investment. Mandatory contributions may not be transferred out of the SMART Capital Preservation Fund.[2]

Additional information regarding the SMART Capital Preservation Fund may be obtained online at **www.mass-smart.com** > *Investing* > *Investment Options* or via the SMART Plan Service Center at **877-457-1900**.

Carefully consider the investment objectives, risks, fees and expenses of the annuity and/or the investment options. Contact us for a prospectus, a summary prospectus and disclosure document, as available, containing this information. Read them carefully before investing.

Administrative Fee

There is a fee of $14.10 per OBRA account, per annum, charged monthly. Fees are used to pay for administrative, recordkeeping, communication and investment education expenses.

Voluntary Contributions

You may make additional contributions (voluntary contributions) above the mandatory contribution of 7.5% of compensation per pay period. Any voluntary contributions that you elect to make may be invested among the SMART Plan's wide array of investment options and are freely transferable among options in accordance with the terms of the SMART Plan. OBRA voluntary contributions will not be charged an additional administrative fee.

To set up voluntary contributions or to learn more, please contact your local SMART Plan Retirement Plan Advisor at **877-457-1900** and say "representative."

Account Management

Once you are enrolled in the SMART Plan, you will have access to your account 24 hours a day, seven days a week through the website at **www.mass-smart.com** or via the SMART Plan Service Center at **877-457-1900**. To register your account for the first time, click on the *REGISTER* button.

Through either the website or SMART Plan Service Center, you can:

- Obtain your account balance(s), allocations and transaction history.
- Obtain investment option information and returns.
- Update your beneficiary information as needed.

Statements

You will receive an annual statement in January of each year showing your contributions as well as any earnings, fees or distributions and the total value of your account. Please review your statement carefully to ensure your information is correct. It is extremely important that you keep the Plan administrator advised of your current address.

To update your address, call the SMART Plan Service Center at **877-457-1900** or visit **www.mass-smart.com**. Once you log into your account, click on your name in the top right corner to update your personal account information.

Distributions

Distribution of your SMART Plan benefits can only be made upon:

- Severance from employment.
- Unforeseeable emergency (OBRA voluntary plan only).
- Attainment of age 70½.
- Your death.

Severance from employment occurs because of your voluntary or involuntary termination of employment. There is no early withdrawal penalty for taking a distribution of your account upon separation of service, regardless of your age.[2]

If you no longer work for the Commonwealth of Massachusetts or a Massachusetts local government employer, you may leave the assets in your OBRA account; take a lump-sum distribution (payable to you or to your beneficiary upon your death); or roll over your assets into another eligible employer-sponsored plan or traditional individual retirement account.

As with any financial decision, you are encouraged to discuss moving money between accounts, including rollovers, with a financial advisor and to consider costs, risks, investment options and limitations prior to investing.

A leave of absence is not a severance from employment. Also, a change from part-time to full-time employment, or any similar change, is not considered an event that could result in a distribution from the SMART Plan. Benefits attributable to your voluntary contribution account may be distributed under other options available in the SMART Plan.

You may elect to receive your distribution immediately upon severance from employment. For more information or to access a Distribution Request form, please contact the SMART Plan Service Center at **877-457-1900** or visit **www.mass-smart.com** > *About your plan* > *OBRA* > *Forms*.

Beneficiaries and Death

If you die before receiving all of your SMART Plan assets, the funds will go to your designated beneficiary. If you do not designate a beneficiary, your funds will be paid to your estate and will be distributed in accordance with Massachusetts probate law. It is essential that you designate a beneficiary on the Enrollment form to ensure your assets will pass on as you intended.

Updating your beneficiary is quick and easy. There are two ways:

Online

Log in to the SMART Plan website at **www.mass-smart.com**. Then go to *My Accounts* > *Beneficiaries*.

Paper

Go to **www.mass-smart.com** > *About your plan* > *OBRA* > *Forms*. Click on the **OBRA Mandatory Beneficiary Designation** form. Mail or fax the completed form to the address or fax number provided on the form.

You will receive a written confirmation after your beneficiary information has been updated. It is extremely important that you keep the Plan administrator advised of your beneficiary changes.

Converting to Full-Time Status

If you become a permanent, full-time employee and at one time made contributions to an OBRA mandatory account, you may elect to transfer your OBRA mandatory account to your voluntary account in the SMART Plan. In order to take advantage of this option, you cannot be actively contributing to the OBRA mandatory plan. To implement this change or to learn more, please contact your local Retirement Plan Advisor at **877-457-1900** and say "representative."

Service Buyback

If you reach a point where you are no longer making OBRA mandatory contributions but you're still working for a Commonwealth of Massachusetts state agency or municipality, you may be eligible for a service buyback of your creditable years of service to your qualified governmental defined benefit retirement plan. Service buybacks may be funded from transferred assets from the OBRA mandatory and/or voluntary contribution accounts.

OBRA and Social Security

Distributions from payments from your OBRA plan may reduce Social Security benefits under the provisions of the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO). Additional information is available in footnote one below or on Form SSA-1945 available on the Social Security Administration website here: *www.socialsecurity.gov/form1945/SSA-1945.pdf.*

To obtain additional information, please call the SMART Plan Service Center at **877-457-1900** from 8 a.m. to 10 p.m. Eastern time Monday through Friday and 9 a.m. to 5:30 p.m. Saturday.

1 The Social Security Administration website at www.socialsecurity.gov/form1945 reminds state and local governmental employers of the requirement under the Social Security Protection Act of 2004 to disclose the effect of the Windfall Elimination Provision (WEP) and the Government Pension Offset (GPO) to employees hired on or after January 1, 2005, in jobs not covered by Social Security. Some jobs may not be covered under Social Security because they are not subject to mandatory coverage and there is no Section 218 agreement that covers them. The GPO provision impacts the amount of Social Security benefits received as a spouse or as an ex-spouse. The WEP affects the retirement or disability benefits received under Social Security if an individual has worked for an employer who does not withhold Social Security taxes. The law requires newly hired public employees to sign a statement, Form SSA-1945, that they are aware of a possible reduction in their future Social Security benefit entitlement. A copy of Form SSA-1945 is available at www.socialsecurity.gov/form1945/SSA-1945.pdf.

2 Withdrawals may be subject to ordinary income tax.

98966-02-03-FLY-386-1812 (20794)-OBRAPH AM679190-1218

DIRECT DEPOSIT

How to Enroll:

On the bottom of your personal check, to the left side, you will locate a nine- digit Bank ID number (transit routing number) alongside these series of numbers will be your account number, WRITE CLEARLY and place these EXACT numbers on the direct deposit form. If the appointee wishes to have his/her check deposited into a savings account, he/she should contact the bank to get the Bank ID number (transit routing number) and account number

Your earnings will be electronically deposited into the bank(s) or credit union you designate (up to a maximum of four accounts) after you complete the Direct Deposit form. A pay statement detailing your earnings and deductions is available online in HR Direct.

OR

GLOBAL CASH CARD PROGRAM

Employees who are experiencing hardship and/or does not submit the direct deposit form will be automatically placed on a "Global Cash Card"

How it Works:

1. Your wages will be deposited onto the Global Cash Card Visa paycard each pay period for immediate use

2. Set up paycard alerts and two-way texting:
   - Receive email and text message alerts when your paycard is loaded on payday
   - Text and receive your paycard balance, activity, and payroll loads within seconds

3. Access your money in many ways:
   - Make signature purchases with No Fee at any merchant that accepts a Visa paycard
   - Receive cash back after making a debit purchase at many locations
   - Withdraw funds at Allpoint Network surcharge-free ATM locations

The World's Largest Surcharge-Free ATM Network. Over 60,000 surcharge-free ATM locations worldwide.Find a location near you at www.allpointnetwork.com

GCC "No Hidden Fees" Detail

PAYCARD PROGRAM	
ENROLLMENT FEE	NO FEE
ANNUAL FEE/MONTHLY FEE	NO FEE
REWARDS PROGRAM	NO FEE
CARD REPLACEMENT	NO FEE
PIN CHANGE	NO FEE
AUTOMATED TELEPHONE	NO FEE
OPERATOR ASSISTED TELEPHONE	NO FEE
WEB SITE LOGIN	NO FEE
INACTIVITY FEE / MONTHLY	$3.00
(AFTER NINETY (90) DAYS OF NO TRANSACTIONS – LOADS ARE TRANSACTIONS)	
FIRST TRANSACTION PER PAY PERIOD	NO FEE
POINT OF SALE – UNITED STATES	
SIGNATURE PURCHASE	NO FEE
PIN PURCHASE	NO FEE
DECLINE – SIGNATURE	$0.80
DECLINE – PIN	$0.50
POINT OF SALE – OUTSIDE UNITED STATES	
SIGNATURE PURCHASE	NO FEE*
PIN PURCHASE	$1.75
DECLINE - SIGNATURE	$1.50
DECLINE – PIN	$1.25
*CURRENCY CONVERSION FEE MAY APPLY	
ATM – UNITED STATES	
WITHDRAWAL (ALLPOINT)	NO FEE
WITHDRAWAL (OUTSIDE OF ALLPOINT NETWORK)	$1.75
OTHER TRANSACTIONS	$1.00
ATM – OUTSIDE UNITED STATES	
WITHDRAWAL	$3.50*
OTHER TRANSACTIONS	$3.25
BALANCE INQUIRY	
ONLINE/IVR/LIVE CUSTOMER SERVICE	NO FEE
MONEY TRANSFER WORLDWIDE (CARD TO CARD)	
$1 - $2500 (DAILY LIMIT IS $2,500)	NO FEE
BILL PAY	
CARDHOLDER DIRECT TO MERCHANT	NO FEE
ONLINE	NO FEE
CONVENIENCE CHECK	NO FEE

If you have any questions about using your Global Cash Card Paycard contact customer service at 1-949-751-0360

University of Massachusetts

AMHERST•BOSTON•DARTMOUTH•LOWELL•WORCESTER

AUTHORIZATION AGREEMENT FOR EMPLOYEE DIRECT PAYROLL DEPOSIT(S)

Employee Name: _____ Effective Date: _____

Employee ID: _____ Phone: _____

BANK INFORMATION

Deposit Priority (1) – Deducts this amount 1st Full/Deposit/Balance ☐ ☐

☐ New ☐ Delete ☐ Change New/Amount $_____ Percentage % _____

Bank Transit/Routing# (9 digits):_____ Account Number: _____

Bank Name:_____ ☐ Checking ☐ Savings

If depositing more than one (1) bank, you must choose one Balance Account

Deposit Priority (2) – Deducts this amount 2nd Full/Deposit/Balance ☐ ☐

☐ New ☐ Delete ☐ Change New/Amount $_____ Percentage % _____

Bank Transit/Routing # (9 digits):_____ Account Number: _____

Bank Name:_____ ☐ Checking ☐ Savings

Deposit Priority (3) – Deducts this amount 3rd Full/Deposit/Balance ☐ ☐

☐ New ☐ Delete ☐ Change New/Amount $_____ Percentage % _____

Bank Transit/Routing # (9 digits):_____ Account Number: _____

Bank Name:_____ ☐ Checking ☐ Savings

Deposit Priority (4) – Deducts this amount 4th Full/Deposit/Balance ☐ ☐

☐ New ☐ Delete ☐ Change New/Amount $_____ Percentage % _____

Bank Transit/Routing # (9 digits):_____ Account Number: _____

Bank Name:_____ ☐ Checking ☐ Savings

I hereby authorize the University of Massachusetts to deposit my net pay as indicated above at the financial institution(s) named above. I understand the University of Massachusetts may cause my account to be adjusted to the extent necessary to correct any over deposit and I agree to hold the above named financial institution(s) harmless for any erroneous deposits or adjustments not caused by the financial institution.
It is understood that I may terminate this agreement at any time by written notification to the University of Massachusetts. Any such notification to the University of Massachusetts shall be effective only with respect to entries initiated by the University after receipt of such notification and reasonable opportunity to act upon it. Any such notification to the bank by the employee is unacceptable. The bank may terminate this agreement by written notice to the employee for just cause.

EMPLOYEE SIGNATURE:_____ DATE: _____

HUMAN RESOURCES USE ONLY:

UMASS BOSTON
UNIVERSITY OF MASSACHUSETTS BOSTON
HUMAN RESOURCES

100 Morrissey Boulevard
Boston, MA 02125-3393
P: 617.287.5150
F: 617.287.5179
www.umb.edu/hr

MEMORANDUM

To: UMass Boston Staff and Faculty
From: Marie H. Bowen, Vice Chancellor for Human Resources
Date: August 23, 2020
Subject: **Annual Notice - Conflict of Interest Law Education Requirements**

The conflict of interest law seeks to prevent conflicts between private interests and public duties, foster integrity in public service, and promote the public's trust and confidence in that service by placing restrictions on what employees of the university may do on the job, after hours, and after leaving public service. The current compliance period for the university runs through December 31, 2020.

Annual conflict of interest law education and training is mandated by the University of Massachusetts Boston and the Commonwealth of Massachusetts, which require that all employees complete the training every two (2) years. New employees should complete the training within thirty (30) days of the date of hire.

In addition to the training requirement, all employees must acknowledge receipt of the state Summary of the Conflict of Interest Law on an annual basis.

To ensure compliance with these conflict of interest requirements, please complete the following steps no later than December 31, 2020.

1. Acknowledge Receipt of the Summary of the Conflict of Interest Law for State Employees:

   The summary of the conflict of interest law, General Laws chapter 268A, is intended to help employees understand how that law applies to them. The summary is not a substitute for legal advice, nor does it mention every aspect of the law that may apply in a particular situation.

   The law requires that receipt of this summary, which may be accessed at http://www.mass.gov/ethics/education-and-training-resources/required-education-and-training/state-employees-summary.html, be acknowledged annually. The university has provided an online option for acknowledging receipt of the summary of the conflict of interest law upon logging in to HR Direct. If you have not already done so, please complete the online process for acknowledging receipt of the summary by clicking the "OK" button on the HR Direct page that appears when you log in and follow the directions provided. If this screen, which has the heading "Attention All Employees" in red font, no longer appears when you log in to HR Direct then you have completed the acknowledgement process for this year and do not need to take further action.

   If you do not have access to HR Direct or otherwise require an alternative to completing the acknowledgement process in the system, please print the version of the summary from the state website, complete and sign the Acknowledgement section at the end of the form and submit it to Human Resources at hr@umb.edu.

2. Complete the Conflict of Interest Law Online Training Program:

   The training program covers various issues you may encounter as a public employee and provides examples and reference information to help you recognize conflicts of interest. Recognizing and properly responding to a conflict of interest is a key element to maintaining the public's confidence in government and in the integrity of the work we do as public employees.

   The training program can be found at: www.stateprog.eth.state.ma.us. It should take approximately one (1) hour to complete.

Upon completion of the training you will have the ability to print a Certificate of Completion. Please do so, make a copy for your records and send the certificate to Human Resources at hr@umb.edu by December 31, 2020. **You must complete the entire training in order to receive a certificate.**

Please note the following before starting the training on the Ethics Commission website:

- Do not use a mobile device, such as a smartphone or tablet, to complete the program.
- Turn off the pop-up blocker in your web browser. The completion certificate displays in a pop-up window. You must disable the pop-up blocker in your web browser before completing the program or you will not be able to print a completion certificate with your name on it. If you are able to proceed through the entire program but your completion certificate does not include your name, position and state agency, you can temporarily disable the pop-up blocker by holding down the "Ctrl" key on your keyboard, and clicking the "View Certificate" button on the program.
- If you choose to print your completion certificate, make sure your computer is connected to a printer.
- If you would like to submit your certificate to HR electronically, you can save the certificate by converting it to a .PDF document. You may also take a screen shot of the certificate or scan a printed copy and email it to HR.
- Please be sure that you follow the above instructions for obtaining the Certificate of Completion as this will be the only record that you have complied with the training requirement. The Ethics Commission will not have any record that you completed the program.
- Do not click the Course Credit button.

If you have questions, please review the Education and Training Guidelines available on the State Ethics Commission's website, www.mass.gov/ethics. The guidelines provide helpful information about who is required to comply with these statutory requirements, record-keeping requirements, and the process.

Thank you for your time and attention to this important matter. If you have any questions, please contact me or any member of the Human Resources team.

Human Resources. **You must complete the entire training in order to receive a certificate.**

NOTE: The online training program is not compatible with the Google Chrome web browser and make sure to disable pop-up blockers.

If you have questions, please review the Education and Training Guidelines available on the State Ethics Commission's website, www.mass.gov/ethics. The guidelines provide helpful information about who is required to comply with these statutory requirements, record-keeping requirements, and the process.

Thank you for your time and attention to this important matter. If you have any questions, please contact Human Resources at hr@umb.edu.

FORM M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 11/19

Print full name ..... Social Security no. .....

Print home address..... City..... State..... Zip .....

Employee:

File this form with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2" .....
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C..... .....
3. Write the number of your qualified dependents. See Instruction D..... .....
4. Add the number of exemptions which you have claimed above and write the total..... ☐
5. Additional withholding per pay period under agreement with employer $_____

A. ☐ Check if you will file as head of household on your tax return.

B. ☐ Check if you are blind. C. ☐ Check if spouse is blind and not subject to withholding.

D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed $8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

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

Date..... Signed .....

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. The more exemptions you claim on this certificate, the less tax withheld from your employer. If you claim more exemptions than you are entitled to, civil and criminal penalties may be imposed. However, you may claim a smaller number of exemptions without penalty. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income. Underwithholding may result in owing additional taxes to the Commonwealth at the end of the year.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions increases. You must file a new certificate within 10 days if the number of exemptions previously claimed by you decreases. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholdingg exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a spouse, write "4" in line 2. Entering "4" makes a withholding system adjustment for the $4,400 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

► **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
► **Give Form W-4 to your employer.**
► **Your withholding is subject to review by the IRS.**

OMB No. 1545-0074

2020

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	**(b) Social security number**
Address		► **Does your name match the name on your social security card?** If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to *www.ssa.gov*.
City or town, state, and ZIP code		

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

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

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

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

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

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

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

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

Step 3: Claim Dependents

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

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

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

Add the amounts above and enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . . **4(a)** $

(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . . **4(b)** $

(c) Extra withholding. Enter any additional tax you want withheld each **pay period** . **4(c)** $

Step 5: Sign Here

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

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

Employers Only

Employer's name and address	First date of employment	Employer identification number (EIN)

General Instructions

Future Developments

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

Purpose of Form

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

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

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

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

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

1. Expect to work only part of the year;

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

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

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

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

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

Specific Instructions

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

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

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

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

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

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

Step 4 (optional).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$220	$850	$900	$1,020	$1,020	$1,020	$1,020	$1,020	$1,210	$1,870	$1,870
$10,000 - 19,999	220	1,220	1,900	2,100	2,220	2,220	2,220	2,220	2,410	3,410	4,070	4,070
$20,000 - 29,999	850	1,900	2,730	2,930	3,050	3,050	3,050	3,240	4,240	5,240	5,900	5,900
$30,000 - 39,999	900	2,100	2,930	3,130	3,250	3,250	3,440	4,440	5,440	6,440	7,100	7,100
$40,000 - 49,999	1,020	2,220	3,050	3,250	3,370	3,570	4,570	5,570	6,570	7,570	8,220	8,220
$50,000 - 59,999	1,020	2,220	3,050	3,250	3,570	4,570	5,570	6,570	7,570	8,570	9,220	9,220
$60,000 - 69,999	1,020	2,220	3,050	3,440	4,570	5,570	6,570	7,570	8,570	9,570	10,220	10,220
$70,000 - 79,999	1,020	2,220	3,240	4,440	5,570	6,570	7,570	8,570	9,570	10,570	11,220	11,240
$80,000 - 99,999	1,060	3,260	5,090	6,290	7,420	8,420	9,420	10,420	11,420	12,420	13,260	13,460
$100,000 - 149,999	1,870	4,070	5,900	7,100	8,220	9,320	10,520	11,720	12,920	14,120	14,980	15,180
$150,000 - 239,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,190	16,050	16,250
$240,000 - 259,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	12,790	13,990	15,520	17,170	18,170
$260,000 - 279,999	2,040	4,440	6,470	7,870	9,190	10,390	11,590	13,120	15,120	17,120	18,770	19,770
$280,000 - 299,999	2,040	4,440	6,470	7,870	9,190	10,720	12,720	14,720	16,720	18,720	20,370	21,370
$300,000 - 319,999	2,040	4,440	6,470	8,200	10,320	12,320	14,320	16,320	18,320	20,320	21,970	22,970
$320,000 - 364,999	2,720	5,920	8,750	10,950	13,070	15,070	17,070	19,070	21,290	23,590	25,540	26,840
$365,000 - 524,999	2,970	6,470	9,600	12,100	14,530	16,830	19,130	21,430	23,730	26,030	27,980	29,280
$525,000 and over	3,140	6,840	10,170	12,870	15,500	18,000	20,500	23,000	25,500	28,000	30,150	31,650

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$460	$940	$1,020	$1,020	$1,470	$1,870	$1,870	$1,870	$1,870	$2,040	$2,040	$2,040
$10,000 - 19,999	940	1,530	1,610	2,060	3,060	3,460	3,460	3,460	3,640	3,830	3,830	3,830
$20,000 - 29,999	1,020	1,610	2,130	3,130	4,130	4,540	4,540	4,720	4,920	5,110	5,110	5,110
$30,000 - 39,999	1,020	2,060	3,130	4,130	5,130	5,540	5,720	5,920	6,120	6,310	6,310	6,310
$40,000 - 59,999	1,870	3,460	4,540	5,540	6,690	7,290	7,490	7,690	7,890	8,080	8,080	8,080
$60,000 - 79,999	1,870	3,460	4,690	5,890	7,090	7,690	7,890	8,090	8,290	8,480	9,260	10,060
$80,000 - 99,999	2,020	3,810	5,090	6,290	7,490	8,090	8,290	8,490	9,470	10,460	11,260	12,060
$100,000 - 124,999	2,040	3,830	5,110	6,310	7,510	8,430	9,430	10,430	11,430	12,420	13,520	14,620
$125,000 - 149,999	2,040	3,830	5,110	7,030	9,030	10,430	11,430	12,580	13,880	15,170	16,270	17,370
$150,000 - 174,999	2,360	4,950	7,030	9,030	11,030	12,730	14,030	15,330	16,630	17,920	19,020	20,120
$175,000 - 199,999	2,720	5,310	7,540	9,840	12,140	13,840	15,140	16,440	17,740	19,030	20,130	21,230
$200,000 - 249,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$250,000 - 399,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,440	19,730	20,830	21,930
$400,000 - 449,999	2,970	5,860	8,240	10,540	12,840	14,540	15,840	17,140	18,450	19,940	21,240	22,540
$450,000 and over	3,140	6,230	8,810	11,310	13,810	15,710	17,210	18,710	20,210	21,700	23,000	24,300

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$830	$930	$1,020	$1,020	$1,020	$1,480	$1,870	$1,870	$1,930	$2,040	$2,040
$10,000 - 19,999	830	1,920	2,130	2,220	2,220	2,680	3,680	4,070	4,130	4,330	4,440	4,440
$20,000 - 29,999	930	2,130	2,350	2,430	2,900	3,900	4,900	5,340	5,540	5,740	5,850	5,850
$30,000 - 39,999	1,020	2,220	2,430	2,980	3,980	4,980	6,040	6,630	6,830	7,030	7,140	7,140
$40,000 - 59,999	1,020	2,530	3,750	4,830	5,860	7,060	8,260	8,850	9,050	9,250	9,360	9,360
$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,780	10,980	11,180	11,580	12,380
$80,000 - 99,999	1,900	4,300	5,710	7,000	8,200	9,400	10,600	11,180	11,670	12,670	13,580	14,380
$100,000 - 124,999	2,040	4,440	5,850	7,140	8,340	9,540	11,360	12,750	13,750	14,750	15,770	16,870
$125,000 - 149,999	2,040	4,440	5,850	7,360	9,360	11,360	13,360	14,750	16,010	17,310	18,520	19,620
$150,000 - 174,999	2,040	5,060	7,280	9,360	11,360	13,480	15,780	17,460	18,760	20,060	21,270	22,370
$175,000 - 199,999	2,720	5,920	8,130	10,480	12,780	15,080	17,380	19,070	20,370	21,670	22,880	23,980
$200,000 - 249,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$250,000 - 349,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,770	24,870
$350,000 - 449,999	2,970	6,470	8,990	11,370	13,670	15,970	18,270	19,960	21,260	22,560	23,900	25,200
$450,000 and over	3,140	6,840	9,560	12,140	14,640	17,140	19,640	21,530	23,030	24,530	25,940	27,240

DISCLOSURE OF NAMES OF FAMILY MEMBERS WHO ARE STATE EMPLOYEES

Disclosure Required by G.L. c. 268A, Sec. 6B

Name of Applicant for Employment: _____

Date: _____

Is your spouse, parent, brother, sister or child, or the spouse of your parent, brother, sister or child, a state employee?

☐ Yes ☐ No

If you answered Yes, please list below the name(s) of any state employee who is your spouse, parent, brother, sister or child, or who is the spouse of your parent, brother, sister or child, and indicate their relationship to you. Please also list the name of the state agency that employs those relatives.

NOTE: For purposes of this disclosure, a "state employee" is a person holding a paid or unpaid office, position, employment or membership in a Massachusetts state agency. For purposes of this disclosure, a "state agency" is any department of Massachusetts state government, including any department or agency within the executive, legislative or judicial branch, and all councils thereof and thereunder, and any division, board, bureau, commission, institution, tribunal or other instrumentality within such department or agency, and any independent state authority, commission, instrumentality or agency, but NOT INCLUDING an agency of a county, city or town.

Name of Relative	**Relationship to Applicant**	**Name of State Agency**

Computer and System Usage

As an employee of the University of Massachusetts (the University), I understand that the unauthorized use or misuse of University computer facilities, computer applications, computer systems, and/or electronic communications systems (including e-mail) constitutes an infraction of the University's data and computing policies/guidelines.

I will not share or release any logon, operator id or password used to access University data, computer systems, or electronic communications systems. I will keep my password(s) confidential, will change my password as required by the computer system and will select a password that is difficult to guess. I will not store access passwords in batch files, in automatic login scripts, in terminal function keys, in computers without access control or in other locations where another person might discover them.

I will not intentionally write, produce, generate, copy, propagate or attempt to introduce a computer virus, worm, Trojan horse, etc. into any University computer system or any computers linked to the University computer system.

I further acknowledge that I will not use University data or computing systems (e.g. software, hardware, network components, etc.) in any illegal, unethical or unauthorized commercial activities.

Data Confidentiality

I recognize my individual responsibility for safeguarding the integrity, accuracy and confidentiality of data that I access as dictated by state and federal law, and University policies and procedures.

I will not improperly release any information obtained as a result of my authorized access.

I will properly create, access, use and dispose of University data based on the data's classification.

Software Usage

I will not knowingly violate the terms of University license agreements for software. I recognize that the University licenses the use of commercial software and does not own this software or its related documentation or instructional material, and except to the extent authorized by the software developer, does not have the right to copy computer software. I will use documentation only as allowed by the vendor and federal Copyright law.

I will not use personally owned software in University computers unless I have a proper license for the software and the license authorizes such use. I will only use such personally owned software in University computers after I have first obtained clearance from appropriate systems personnel as to its compatibility with University computers and systems.

I will not illegally distribute copyrighted software within or outside the University through any mechanism, electronic or otherwise. I will not use my e-mail access to unlawfully solicit or exchange copies of copyrighted software.

(1) As directed by Board of Trustees' Policy Statements on Electronic Data Security, Electronic Mail and Computer Policy Development (Doc. T97-010, adopted February 5, 1997), and Policy Statement on Record Management, Retention and Disposition (Doc. T99-061 adopted August 4, 1999). Full text of these Policies and related Guidelines and all University Data and Computing Guidelines can be found at: https://www.umassp.edu/bot/policies

Electronic Communications

I will use e-mail and any other electronic communications tool in a responsible manner consistent with other business communications (e.g., phone, correspondence). I will safeguard the integrity and confidentiality of University electronic mail; only use mail IDs assigned to me and will remove mail from my mailbox consistent with University, campus, departmental or electronic mail administrator message retention procedures.

I will not "rebroadcast"/send to a third party information obtained from another individual that the individual reasonably expects to be confidential, except as required by my job responsibilities, University policies and procedures, and applicable law.

I will not post materials that violate existing laws or University policies/codes of conduct. For example, materials that are of a fraudulent, defamatory, harassing, or threatening nature. I will not unnecessarily or inappropriately use computer resources by sending chain e-mails, spamming, mail bombing, generating unnecessary excessive print, etc.

My Responsibilities

I have agreed and will attend a workshop that includes information regarding my computer security and data confidentiality responsibilities as an employee of the University. I understand these responsibilities both as an authorized user and an employee.

I recognize my overall responsibility to exercise the degree of care required to maintain control of University computing systems and resources (e.g., data, software, hardware, network components, etc.) and agree to abide by established University policies/guidelines and Campus procedures. I acknowledge that failure to comply with University data and computing related policies/guidelines/procedures might result in: the loss or restriction of my computer access; reprimand; suspension; dismissal, or other disciplinary or legal action.

Print Name

Signature *Date*

(1) As directed by Board of Trustees' Policy Statements on Electronic Data Security, Electronic Mail and Computer Policy Development (Doc. T97-010, adopted February 5, 1997), and Policy Statement on Record Management, Retention and Disposition (Doc. T99-061 adopted August 4, 1999). Full text of these Policies and related Guidelines and all University Data and Computing Guidelines can be found at: https://www.umassp.edu/bot/policies

University of Massachusetts
Amherst • Boston • Dartmouth • Lowell • Medical School • UMassOnline

NOTICE AND ACKNOWLEDGEMENT
PAID FAMILY AND MEDICAL LEAVE LAW
MGL c. 175M

In 2018, Massachusetts signed into law a statute that provides paid family and medical leave (PFML) benefits to public and private workers. That law requires covered employers to provide employees with notice of the benefits and the employer/employee contributions for the Paid Family Medical Leave program. The University of Massachusetts is providing you with this notice in order to comply with this requirement. Options and instructions for how to acknowledge this notice are located at the bottom of this document.

Explanation of Benefits

- **Beginning January 1, 2021,**
  - employees may be entitled to up to 12 weeks of paid family leave in a benefit year for the birth, adoption, or foster care placement of a child, or because of a qualifying exigency arising out of the fact that a family member is on active duty or has been notified of an impending call to active duty in the Armed Forces.
  - employees may be entitled to up to 20 weeks of paid medical leave in a benefit year if they have a serious health condition that incapacitates them from work.
  - employees may be entitled to up to 26 weeks of paid family leave in a benefit year to care for a family member who is a covered service member undergoing medical treatment or otherwise addressing consequences of a serious health condition relating to the family member's military service.

- **Beginning July 1, 2021,**
  - employees may be entitled to up to 12 weeks of paid family leave in a benefit year to care for a family member with a serious health condition.

Employees may be eligible for up to 26 total weeks, in the aggregate, of paid family and medical leave in a single benefit year. An employee's weekly benefit amount will be based on the employee's earnings, with a percentage of wages up to a maximum benefit of $850 per week.

Leave taken under M.G.L. c. 175M shall run concurrently with leave taken under other applicable state and federal leave laws, including but not limited to, the Commonwealth's Parental Leave Act (section 105D of M.G.L. c. 149), the federal Family and Medical Leave Act of 1993 (29 U.S.C. 2601 et seq.), as amended, when the leave is for a qualified reason under those acts.

In some instances, paid leave provided under a collective bargaining agreement or employer policy and paid at the same or higher rate than paid leave available under this law may count against the allotment of leave benefits available under this law.

Employer/Employee Contributions to the DFML Family and Employment Security Trust Fund

- On October 1, 2019, contributions to the Department of Family and Medical Leave (DFML) Employment Security Trust Fund will begin. An employer will be responsible for sending contributions to the DFML for all employees.

- Currently, the total contribution amount is 00.75% of wages. Of that 00.75% total contribution amount, there is a split: 17.5% is a family leave contribution and 82.5% is a medical leave contribution.

- Under the law, employers are permitted to deduct from employees' wages up to 40% of the medical leave contribution and up to 100% of the family leave contribution.

- As an employee of the University of Massachusetts, the Default Employee Share from your earnings is as follows:

    - 40% of the Medical Leave Contribution
    - 100% of the Family Leave Contribution

  Your employer will contribute:

    - 60% of the Medical Leave Contribution
    - 0% of the Family Leave Contribution

Job Protection, Continuation of Health Insurance and No Retaliation

- **Job Protection:** Generally, an employee who has taken family or medical leave under the law must be restored to the employee's previous position or to an equivalent position, with the same status, pay, employment benefits, length-of-service credit and seniority as of the date of leave.

- **Continuation of Health Insurance:** The employer must continue to provide for and contribute to the employee's employment-related health insurance benefits, if any, at the level and under the conditions coverage would have been provided if the employee had continued working continuously for the duration of such leave.

- **No Retaliation:** It is unlawful for any employer to discriminate or retaliate against an employee for exercising any right to which such employee is entitled under the paid family and medical leave law. An employee or former employee who is discriminated or retaliated against for exercising rights under the law may, not more than three years after the violation occurs, institute a civil action in the superior court.

How to File a Claim

- Employees must file claims for paid family and medical leave benefits with the DFML using the Department's forms. Forms and claim instructions will be available on the Department's website www.mass.gov/DFML before January 2021.

- Employees are required to provide at least 30 days' notice to their employer of the anticipated starting date of Paid Family Medical Leave, the anticipated length of the leave and the expected date of return. An employee who is unable to provide 30 days' notice due to circumstances beyond his or her control is required to provide notice as soon as practicable.

Contact Information

The Massachusetts Department of Family and Medical Leave

Charles F. Hurley Building
19 Staniford Street, 1st Floor Boston, MA 02114
(617) 626-6565
MassPFML@mass.gov

For more detailed information, please consult the Department's website: **www.mass.gov/DFML**.

For the purposes of this notification your employer is:

Commonwealth of Massachusetts
1 Ashburton Place Room 901
Boston, MA 02108
Employer ID# 04-6002284

Options and Instructions for Acknowledgement

You have three options for acknowledging receipt of this Notice:

1. Select the link to HR Direct that is embedded in the email that you received or log onto HR Direct.
2. Print the portion of this document entitled "PFML Notice Acknowledgement Form", sign it, and mail it to the UMass Presidents Office, Human Resources Office, 333 South Street, Suite 400, Shrewsbury, MA 01545.
3. Print the portion of this document entitled "PFML Notice of Acknowledgement Form" and have it hand delivered to any of the locations listed below. You can also pick up a printed copy of the regulations and the acknowledgement form at these locations.

Drop-off Locations

UMASS LOWELL
Human Resources & Equal Opportunity & Outreach
600 Suffolk Street
Lowell, MA 01854

UMASS DARTMOUTH
Human Resources Office
Foster Administration Building, Room 202
285 Old Westport Road
Dartmouth, MA 02747

UMASS BOSTON
Human Resources Office
Quinn Administration Building, Room 076
100 Morrissey Blvd
Boston, MA 02125

UMASS MEDICAL SCHOOL

Main Campus
Room S2-100A
55 North Lake Ave
Worcester, MA 01655

Office Hours:
Wed. 2 – 3pm
Thurs. 10am – 11 am
Fri. 11am -12pm

Shrewsbury Location
Human Resources
333 South Street
Shrewsbury, MA

Quincy Location
Joan Wall – Office 7026
100 Hancock Street
Quincy, MA 02171

MassBiologics Location
Jeffery Way - Office# 1017
Administration & Research Building
Mattapan, MA 02124

Charlestown Location (Schrafft's Building)
Bonnie Kumar – Office 3.401
529 Main Street
Schrafft City Center
Charlestown, MA 02129

UMASS PRESIDENT'S OFFICE

Shrewsbury Location
Human Resources Office
333 South Street, Suite 400
Shrewsbury, MA 01545

Boston Location
Brian Melanson – A&F
One Beacon – 31st floor

PFML NOTICE ACKNOWLEDGEMENT FORM

PAID FAMILY AND MEDICAL LEAVE LAW MGL c. 175M

Please complete only one of the two boxes below:

Your signature below acknowledges your receipt of the Paid Family and Medical Leave Notice and Acknowledgement Form.

_____

Signature **Date**

_____

Name (Print) **Campus** **Employee ID**

Your signature below indicate you have declined to acknowledge receipt of the Paid Family and Medical Leave Notice and Acknowledgement Form.

_____

Signature **Date**

_____

Name (Print) **Campus** **Employee ID**

Your signed acknowledgement, or statement indicating your refusal to sign the acknowledgement, will be retained by your employer. You may retain a copy for your own reference.

UMASS BOSTON
UNIVERSITY OF MASSACHUSETTS BOSTON
HUMAN RESOURCES

100 Morrissey Boulevard
Boston, MA 02125-3393
P: 617.287.5150
F: 617.287.5179
www.umb.edu/hr

NON-BENEFITED STAFF

WRITTEN NOTICE OF ACKNOWLEDGEMENT and CONDITIONAL EMPLOYMENT FORM

As a prospective/current 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 of my intent to withdraw consent to a background check and a CORI check to Human Resources. For more information see UMB policy on background checks at https://hr.umb.edu/uploads/documents/Background_Check_Policy_october_2015_FINAL_revised_9_16_15.pdf.

As a prospective/current 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 with an @umb.edu email address.

As a prospective/current 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.

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 attest that the information provided to the University is true and accurate to the best of my knowledge and I understand that:

- Falsification of any such information-whenever discovered-could result in termination.
- If I do not satisfactorily complete my background review this offer will be withdrawn.
- If I commence employment it will be conditioned on a successful completion of a background review.
- I will be terminated if the background review is not successful.

I provide my consent for a background check and CORI check and acknowledge that the information provided on Page 2 of this Request Form is true and accurate.

_____ _____

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 (Jr., III, etc.)**

_____

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

☐ _____ _____-_____

Check if under Age 18 **Date of Birth (MM/DD/YYYY)** **Last 6 Digits of your SSN**

_____

Current and valid e-mail address (PLEASE NOTE: Human Resources WILL CONTACT YOU AT THIS EMAIL ADDRESS and Creative Services Inc., if needed.)

_____

Current Mailing Address

Hiring Department

To be completed by Supervisor or Department Head ONLY:

This document is intended to verify the authenticity of physical identity documents such as driver's license, passport, etc. of the employee above named and has provided you to the best of your satisfaction such identification in order to complete this form.

Complete all fields below:

VERIFIED BY: _____ _____

Print Name of Verifying Employee Signature of Verifying Employee

Hiring Department: _____

Extension: _____ **E-Mail Address:** _____

Job Title of new employee/volunteer: _____

Name of new employee/volunteer's supervisor: _____

Please provide a brief description of the work being performed (attach additional information if needed):

_____