COUNTY OF RIVERSIDE
HUMAN RESOURCES DEPARTMENT

EMPLOYMENT DECLARATION FORM

Name (Last, First, Middle Initial)	Social Security Number	Telephone

Physical Address (Street/P.O. Box, City, Postal Code

Mailing Address if Different (Street/P.O. Box, City, Postal Code	Driver's License Number, Class, and Exp. Date

Department	Position Title	Employee ID (if available)

Are you retired under the California Public Employees Retirement System (CalPERS)? ☐No ☐Yes

Are you enrolled with the California Public Employees Retirement System (CalPERS) as a result of working for another CalPERS employer? ☐No ☐Yes

List All Previous Names Under Which You Have Been Employed	Language(s) other than English in which you are fluent:

Employment of Relatives: No employee may execute direct supervision over or initiate or participate in decisions (including but not limited to initial employment, retention, evaluation, promotion, or work assignments) specifically pertaining to another County of Riverside employee who is related as spouse, father, mother, brother, sister, son, daughter, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, or the equivalent through registered domestic partnership (County of Riverside Salary Ordinance, Ord. No. 440).

List all close relatives, as defined above, and the Agency or Department in which they work. Do not specify the relationship.

_____

DECLARATION

By my signature below, I declare that all information provided on this Employment Declaration Form and all documentation submitted for employment to the County of Riverside is true and complete. I understand that falsification of information is grounds for disqualification or termination if hired. I authorize the County of Riverside and its agents to verify any information related to my Employment Declaration Form or continued employment with the County of Riverside and I authorize the release of any such information. I release the County and its agents from any and all liability for damage of whatever kind for seeking such information.

_____ _____
Signature Date

The information you provide in this section is voluntary and confidential. It will be used for statistical reporting only.

Gender: ☐Male ☐Female

Are you a Veteran of the United States Armed Forces with an honorable discharge having served during an expeditionary period or declared war? ☐No ☐Yes

Ethnic/Racial Group (Indicate one with which you most closely identify):

☐ Hispanic or Latino
☐ White (Not Hispanic or Latino)
☐ Black or African American (Not Hispanic or Latino)
☐ Native Hawaiian/Pacific Islander (Not Hispanic or Latino)
☐ American Indian/Alaskan Native (Not Hispanic or Latino)
☐ Asian (Not Hispanic or Latino)
☐ Two or More Races (Not Hispanic or Latino)

Form W-4 (2019)

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

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

Exemption from withholding. You may claim exemption from withholding for 2019 if **both** of the following apply.

- For 2018 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2019 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2019 expires February 17, 2020. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2019 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income not subject to withholding outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2019. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married filing jointly and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income not subject to withholding, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Additional Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you may claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you may be eligible to claim a child tax credit for each of your eligible children. To qualify, the child must be under age 17 as of December 31, must be your dependent who lives with you for more than half the year, and must have a valid social security number. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line F. Credit for other dependents. When you file your tax return, you may be eligible to claim a credit for other dependents for whom a child tax credit can't be claimed, such as a qualifying child who doesn't meet the age or social security number requirement for the child tax credit, or a qualifying relative. To learn more about this credit, see Pub. 972. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total

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Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2019

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

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages)	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2019, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

8 Employer's name and address (**Employer:** Complete boxes 8 and 10 if sending to IRS and complete boxes 8, 9, and 10 if sending to State Directory of New Hires.)	**9** First date of employment	**10** Employer identification number (EIN)

income includes all of your wages and other income, including income earned by a spouse if you are filing a joint return.

Line G. Other credits. You may be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as tax credits for education (see Pub. 970). If you do so, your paycheck will be larger, but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account. Enter "-0-" on lines E and F if you use Worksheet 1-6.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income, such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income not subject to withholding, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/css/employers.***

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	**A**	
B	Enter "1" if you will file as married filing jointly	**B**	
C	Enter "1" if you will file as head of household	**C**	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**D**	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $179,051 to $200,000 ($345,851 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	**E**	
F	**Credit for other dependents.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $71,201 ($103,351 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $71,201 to $179,050 ($103,351 to $345,850 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $179,050 ($345,850 if married filing jointly), enter "-0-"	**F**	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here. If you use Worksheet 1-6, enter "-0-" on lines E and F	**G**	
H	Add lines A through G and enter the total here ►	**H**	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income not subject to withholding and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work,** and the combined earnings from all jobs exceed $53,000 ($24,450 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income not subject to withholding.

1	Enter an estimate of your 2019 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 10% of your income. See Pub. 505 for details	**1**	$
2	Enter: $24,400 if you're married filing jointly or qualifying widow(er); $18,350 if you're head of household; $12,200 if you're single or married filing separately	**2**	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	**3**	$
4	Enter an estimate of your 2019 adjustments to income, qualified business income deduction, and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	**4**	$
5	**Add** lines 3 and 4 and enter the total	**5**	$
6	Enter an estimate of your 2019 nonwage income not subject to withholding (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	**7**	$
8	**Divide** the amount on line 7 by $4,200 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H, above	**9**	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 of that worksheet on page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1 Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet) . . . . . 1 _____

2 Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3" . . . . . 2 _____

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

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

4 Enter the number from line 2 of this worksheet . . . . . 4 _____

5 Enter the number from line 1 of this worksheet . . . . . 5 _____

6 **Subtract** line 5 from line 4 . . . . . 6 _____

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

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

9 **Divide** line 8 by the number of pay periods remaining in 2019. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2019. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . 9 $ _____

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 13,000	1
9,501 - 19,500	2	13,001 - 27,500	2
19,501 - 35,000	3	27,501 - 32,000	3
35,001 - 40,000	4	32,001 - 40,000	4
40,001 - 46,000	5	40,001 - 60,000	5
46,001 - 55,000	6	60,001 - 75,000	6
55,001 - 60,000	7	75,001 - 85,000	7
60,001 - 70,000	8	85,001 - 95,000	8
70,001 - 75,000	9	95,001 - 100,000	9
75,001 - 85,000	10	100,001 - 110,000	10
85,001 - 95,000	11	110,001 - 115,000	11
95,001 - 125,000	12	115,001 - 125,000	12
125,001 - 155,000	13	125,001 - 135,000	13
155,001 - 165,000	14	135,001 - 145,000	14
165,001 - 175,000	15	145,001 - 160,000	15
175,001 - 180,000	16	160,001 - 180,000	16
180,001 - 195,000	17	180,001 and over	17
195,001 - 205,000	18		
205,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,900	$420	$0 - $7,200	$420
24,901 - 84,450	500	7,201 - 36,975	500
84,451 - 173,900	910	36,976 - 81,700	910
173,901 - 326,950	1,000	81,701 - 158,225	1,000
326,951 - 413,700	1,330	158,226 - 201,600	1,330
413,701 - 617,850	1,450	201,601 - 507,800	1,450
617,851 and over	1,540	507,801 and over	1,540

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

You aren't required to provide the information requested on a form that's 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.

NOTICE OF EXCLUSION FROM CalPERS MEMBERSHIP

1. SOCIAL SECURITY NUMBER	**Your employer has contracted with the California Public Employees' Retirement System (CalPERS) to provide an employee benefit package which includes service retirement, death, and disability benefits.**

2. CURRENT NAME (LAST) (FIRST) (MIDDLE)

3. NAME OF PUBLIC AGENCY	4. DEPARTMENT OR SCHOOL DISTRICT	5. JOB OR POSITION TITLE
County of Riverside	HR-TAP	Temporary Assistant

6. TERM OF APPOINTMENT	7. IF TEMPORARY, ENTER NEAREST NUMBER OF WHOLE MONTHS THE APPOINTMENT IS EXPECTED TO LAST.	8. APPOINTMENT DATE MM	DD	YYYY
☐ PERMANENT ☒ TEMPORARY	6 MONTHS			

9. TIME BASE

☐ FULL-TIME ☒ INDETERMINATE ☐ PART-TIME IF PART TIME, ENTER THE FRACTION OF FULL TIME:

In your present position with this agency, you are excluded from CalPERS membership because:

☐ 1. Your full-time seasonal or limited term appointment is limited to 6 months or less.

☐ 2. Your part-time appointment is limited to less than an average of 20 hours per week for less than one year.

☒ 3. Your appointment is an on-call, intermittent, emergency, substitute, or other irregular basis which excludes you from membership until you have worked 1,000 hours (or 125 days if paid on per diem basis) this fiscal year.

☐ 4. Your position is excluded by law or by contract agreement which excludes:
_____ Enter contract exclusion (for Public Agencies only).

☐ 5. You are an independent contractor.

☐ 6. You are employed to render professional legal service to a city.
Exceptions: Persons holding the office of city attorney, deputy city attorney, or assistant city attorney.

☐ 7. You are employed as a student aide by a school district in a position established for students only and you are attending school in the same district (for County Schools only).

NOTE: If you are a member of CalPERS by previous employment (either you have funds on deposit or service credit), exclusions 1, 2, and 3 do not apply to you and you should be a member in your present position. Be sure to notify your employer to complete a (PERS-1) Member Action Request Form or appoint via ACES to report your employment to CalPERS.

If you believe that your employment <u>does</u> qualify you for CalPERS membership, ask your employer for an explanation. You can also contact CalPERS directly by sending a letter stating the reasons why you feel you should be a member to the Employer Account Management Division, Membership Management Section, P.O. Box 942709, Sacramento, CA 94229-2709.

SIGNATURE OF CERTIFYING OFFICER	TITLE	DATE

SIGNATURE OF EMPLOYEE	DATE

NOTE: Benefits provided by CalPERS are described in the "CalPERS Benefits" information booklet available from your employer.

California Public Employees' Retirement System
P.O. Box 942709 Sacramento, CA 94229-2709
888 CalPERS (or **888**-225-7377)
TTY: (877) 249-7442 | Fax: (916) 795-4166
www.calpers.ca.gov

Reciprocal Self-Certification Form

*Complete the following information and return this form to your personnel office **within 10 business days.** To ensure this form is completed correctly, please reference the enclosed List of Qualifying Public Retirement Systems and instructions.*

Section 1. Member Information

Member Name: (Last)	(First)	(Middle)
Date of Birth:	CalPERS ID:	

Membership Status in Qualifying Public Retirement Systems:

☐ I have not been a member of a qualifying public retirement system in California. (skip to section 3)

☐ I have membership in a defined benefit plan under a qualifying public retirement system in California other than CalPERS. (complete section 2 with membership information for each qualifying public retirement system)

Section 2. Qualifying Reciprocal Membership Information

Name of Most Recent Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /
Name of Prior Public Retirement System:	Membership Date: / /	Separation Date*: / /	☐Retired* or ☐Refunded* Date: / /

**Please provide dates, if applicable. Not all sections may be applicable for each Public Retirement System.*

Section 3. Sign and Certify

I understand that by accepting employment in a qualified public retirement system, I am subject to the applicable laws and regulations of that system. **I also understand that completing this form is not a request to establish reciprocity.**

I hereby certify that the foregoing information has been verified with the qualifying public retirement system as true and correct and any information found to be incorrect may require corrections to my CalPERS account including, but not limited to, my retirement enrollment level and adjustments to my member contributions. CalPERS may make any necessary corrections to my account to ensure I am properly enrolled and eligible to receive the correct retirement benefits.

Member Signature: *Date:*

Section 4. To Be Completed by Employer Only

Name of CalPERS Agency:

CalPERS Business Partner ID:	Member's Enrollment Eligibility Date:
Designee of Employer: (print name)	Designees' Title:
Designee Signature:	*Date:*

The employer must retain this form in the member's file for auditing purposes.

For more direction regarding how to process the Reciprocal Self-Certification Form, please refer to our employer reference guides.

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

Employee Name _____ **Employee ID#** _____

Employer Name _____ **Employer ID#** _____

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 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is $395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to 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 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 about Social Security Form SSA-1945 Statement Concerning Your Employment in a Job Not Covered by Social Security

New legislation [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 should use to meet the requirements of the law. The SSA-1945 explains the potential effects of two provisions in the Social Security law for workers 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 a worker's Social Security retirement or disability benefit. The Government Pension Offset Provision can affect a Social Security benefit received as a spouse, surviving spouse, or an ex-spouse.

Employers must:

- Give the statement to the employee prior to the start of employment;
- Get the employee's signature on the form; and
- Submit a copy of the signed form to the pension paying agency.

Social Security will not be setting any additional guidelines for the use of this form.

Copies of the SSA-1945 are available online at the Social Security website, www.socialsecurity.gov/online/ssa-1945.pdf. Paper copies can be requested by email at ofsm.oswm.rqct.orders@ssa.gov or by fax at 410-965-2037. The request must include the name, complete address and telephone number of the employer. Forms will not be sent to a post office box. Also, if appropriate, include the name of the person to whom the forms are to be delivered. The forms are available in packages of 25. Please refer to Inventory Control Number (ICN) 276950 when ordering.

COUNTY OF Riverside
HUMAN RESOURCES
Winner IPMA Award for Excellence

401(a) PART-TIME & TEMPORARY EMPLOYEES' RETIREMENT PLAN
P.O. BOX 1569 · RIVERSIDE, CA 92502-1569
(951) 955-4981, OPTION 2 · (951) 955-8538 FAX
RETIREMENT@RC-HR.COM · HTTP://BENEFITS.RC-HR.COM

TEMPORARY PLAN ELIGIBILITY SELF-CERTIFICATION FORM

Provide the following information

Employee Name:_____
(Last) (First) (Middle)

Employee ID #:_____ Date of Hire:_____

(Check the applicable statement)

☐ 1. I am not an active member of another public retirement system.

☐ 2. I am an active member of another public retirement system:

Name of public retirement system:_____

Name of employer: _____

Membership date in other public retirement system:_____

☐ 3. I am a retiree of a public retirement system.

Name of public retirement system:_____

Name of employer: _____

Membership date in other public retirement system:_____

I understand that participation in the County of Riverside 401(a) Part-Time and Temporary Employees' Retirement Plan (the "Plan") is required if you are designated as a Part-time, Seasonal or Temporary employee and you are excluded from participation in CalPERS. The Plan is offered in lieu of Social Security.

I acknowledge receipt of the Summary Plan Description ("SPD") for the County of Riverside Part-Time and Temporary Employees' Retirement Plan which is intended to provide a summary of the Plan and was also informed that I may obtain a copy of the SPD from the Human Resources website at http://benefits.rc-hr.com/. I acknowledge that eligibility into this plan is not permitted as a "rehired annuitant" governed under the Public Employees' Retirement Law (PERL); while participating under another retirement system maintained by the County of Riverside; or while working in a job classification that is excluded from participation. I may become eligible for the Plan if my employment status changes. It is my responsibility to notify the County if my eligibility to participate in the Plan changes at any time during the term of my employment.

I hereby certify that the foregoing information is true and correct and any information found to be incorrect may require corrections to my account in the Plan. The County of Riverside reserves the right to amend my account to ensure eligibility requirements are met in accordance with provisions in the Plan document or applicable Federal law.

_____ _____
Employee Signature Date

Employee #_____

County of Riverside
Part-Time & Temporary Employees' Retirement Plan

Retirement Unit
P.O. Box 1569
Riverside, CA 92502-1569

BENEFICIARY DESIGNATION FORM

I. Personal Information (please print all information on this form; use additional sheets as necessary)

Participant Name	Social Security Number	Date of Birth

Address	City	State	Zip code

Name, Relationship and Telephone Number of Closest Living Relative (Note: This Relative does not have to be named below as one of your Beneficiaries)

Name	Relationship	Telephone Number

II. Principal Beneficiary Designation (All Principal Beneficiaries who survive you shall share equally in any benefits payable upon your death unless you specify otherwise)

Name	Social Security Number	Relationship	Date of Birth	Share

III. Contingent Beneficiary Designation (the Contingent Beneficiary will be paid any benefits due should the Principal Beneficiary pre-decease you)

Name	Social Security Number	Relationship	Date of Birth	Share

I hereby revoke all previous Beneficiary designations, which I have made.

Participant's Signature	Date	Spouse's Signature	Date

COUNTY OF RIVERSIDE

DESIGNATION OF PERSON TO RECEIVE WARRANTS OR CHECKS UPON DEATH OF EMPLOYEE

PRINT OR TYPE (LAST NAME) (FIRST NAME) (INITIAL)

In the event of my death, I hereby designate the person named below as being entitled to receive all warrants or checks that will be payable to me by the County of Riverside.

NAME OF PERSON TO RECEIVE YOUR CHECKS IN CASE OF YOUR DEATH

Name:_____

Address:_____

Relationship: _____ Soc.Sec.No.: _____
(REQUIRED)

Note: Identification documents will be required to be presented since warrants and checks can only be dispersed to your designee after sufficient proof of identity is provided.

_____ _____
Signature Date

_____
Employee ID

UPON DEATH OF EMPLOYEE - Government Code 53245

Any person now or hereafter employed by the County may file with his/her appointing power a designation of a person who, notwithstanding any other provisions of law, shall on the death of the employee, be entitled to receive all warrants or checks that would have been payable to the descendent had he/she survived. The employee may change the designation from time to time. A person so designated shall claim such warrants or checks from the appointing power. A person who received a warrant or check pursuant to this section is entitled to negotiate it as if he/she were the payee.

IMPORTANT: Please fill out the above information completely. We cannot accept an incomplete form. Please return to:

HUMAN RESOURCES/ EMPLOYEE SERVICES – MAIL STOP #1150
or
P. O. BOX 1569, RIVERSIDE, CA 92502-1569

9/21/2009

FAXES ARE NOT ACCEPTED

AUDITOR CONTROLLER
COUNTY OF RIVERSIDE

DIRECT DEPOSIT REQUEST FORM

You are limited to three (3) accounts.

Employee ID (required)	**Department**
Last Name	**First Name**

CHECKING ACCOUNTS

Complete the checking account section only and attach a voided check for each checking account listed.

Bank Name	Routing #	Account Number	% of Net Pay	Dollar Amount
Global Cash Pay Card				

SAVINGS ACCOUNTS

Complete the savings account section only and attach documentation from the bank for each account listed.

Bank Name	Routing #	Account Number	% of Net Pay	Dollar Amount

I authorize the County of Riverside to initiate deposits (credits) and/or corrections to the financial institutions indicated herein. The financial institution is authorized to credit and/or correct the amounts to my account. This authority will remain in full force and effect until the County has received written notification from me in the form of a revised authorization, canceling this authorization in such time and such manner as to afford the County and depositor a reasonable opportunity to act on it. I authorize the County of Riverside to deposit my final paycheck including all accrued but unused leave balances. I understand it may take up to three (3) pay periods for this authorization to become effective during which time I will receive a mailed warrant (check). No mark outs or alternation to this paragraph will be accepted.

Employee Signature (required)	**Date**
Please enter a phone # that you can be reached at during the hours of 7:30AM - 5:00PM. If we are unable to contact you, processing of request may be delayed.	**Telephone Number**

AUDITOR-CONTROL LER USE ONLY

Pay Period Processed	**Keyed By**	**Date Entered**

MAIL STOP 1160 OR MAIL TO PO BOX 1326, RIVERSIDE, CA 92502

Revised 01/2017

EMPLOYEE ACKNOWLEDGEMENT OF THE MEDICAL PROVIDER NETWORK

In order to provide the most timely and suitable quality medical care in the event of an injury on the job, the County of Riverside has instituted a Medical Provider Network for Workers' Compensation.

The following procedures must be followed for all work related injuries and illnesses.

- Report promptly any work related injury to the supervisor.
- For a referral to a medical provider specialist, contact your Supervisor, Manager, or Claims Adjuster.
- Ensure all medical treatment is handled only through the MPN (Medical Provider Network) unless otherwise authorized.
- Direct all questions about the level of care to the PCP (Primary Care Physician), who is the focal point for all medical treatment.
- A directory of medical care providers is available at my request through the Workers' Compensation Division.

Please sign below to indicate that you have read and understand the procedures to follow in the event of an injury and your duties under our Medical Provider Network.

Print Name

Date

County of Riverside

Employee Signature

Employer

Employee Number

A COPY OF THE MPN DIRECTORY IS AVAILABLE FROM YOUR EMPLOYER OR ADJUSTER UPON YOUR REQUEST.

RECONOCIMIENTO DEL EMPLEADO DE LA MEDICAL PROVIDER NETWORK

Para brindar atención médica de la más rápida y de apropiada calidad en el evento de una lesión ocasionada en el trabajo, hemos instituido una Red de Proveedores Médicos para Compensación Laboral.

Los procedimientos siguientes deben ser seguidos para todas las lesiones y enfermedades ocasionadas en el trabajo.

- Reporte inmediatamente a su supervisor cualquier lesión ocasionada en el trabajo.
- Para una referencia a un médico especialista, comuníquese con su empleador o ajustador de reclamos.
- Cerciórese que todo tratamiento médico sea manejado únicamente por la MPN (Red de Proveedores Médicos), a menos que de otro modo autorizado
- Dirija toda pregunta sobre el nivel de cuidado al PCP (Primary Care Physician – Médico de Cabecera), quien es el punto de referencia para todo tratamiento médico.
- Un directorio de proveedores de cuidado médico está disponible al solicitarlo a través de mi empleador.

Por favor firmar abajo para indicar que usted ha leído y entendido los procedimientos que se siguen en el evento de una lesión y sus responsabilidades bajo nuestra Red de Proveedores Médicos.

Nombre en Imprenta

Fecha

Firma del Empleado

Empleador County of Riverside

Número del Empleado

UNA COPIA DEL DIRECTORIO DE LA MPN ESTA DISPONIBLE DE SU EMPLEADOR O AJUSTADOR AL SOLICITARLO.

COUNTY OF Riverside
TEMPORARY ASSIGNMENT PROGRAM

Employee Emergency Information

Please Print

Date:_____

Personal Information:

Employee Name:_____ Home #:_____

County Employee ID Number:_____Cell/Other:_____

Complete Home Address: _____

_____

Emergency Contact:_____ Relationship:_____

Home #:_____Work #:_____ Cell/Other: _____

Alternate Contact:_____ Relationship:_____

Home #:_____Work #:_____ Cell/Other: _____

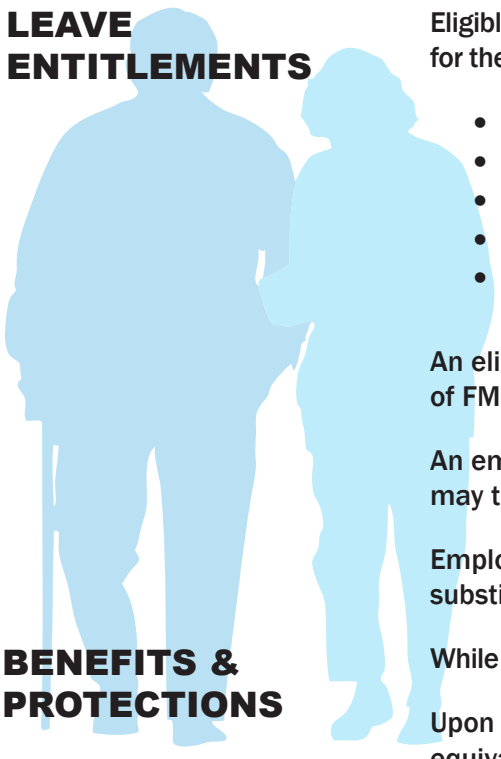
Name of Doctor:_____ Office Phone:_____

_____ _____ _____

Employee Print Employee Sign Date

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

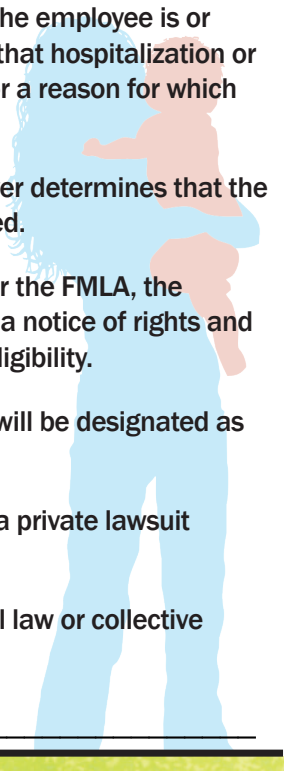
*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.



EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Sign:_____ Date:_____

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WAGE AND HOUR DIVISION

EMPLOYERS MUST PROVIDE THIS INFORMATION TO NEW WORKERS WHEN HIRED AND TO OTHER WORKERS WHO ASK FOR IT

RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING

Your Right to Take Time Off:

- You have the right to take time off from work to get help to protect you and your children's health, safety or welfare. You can take time off to get a restraining order or other court order.
- If your company has 25 or more workers, you can take time off from work to get medical attention or services from a domestic violence shelter, program or rape crisis center, psychological counseling, or receive safety planning related to domestic violence, sexual assault, or stalking.
- You may use available vacation, personal leave, accrued paid sick leave or compensatory time off for your leave unless you are covered by a union agreement that says something different. Even if you don't have paid leave, you still have the right to time off.
- In general, you don't have to give your employer proof to use leave for these reasons.
- If you can, you should tell your employer before you take time off. Even if you cannot tell your employer before, your employer cannot discipline you if you give proof explaining the reason for your absence within a reasonable time. Proof can be a police report, court order or doctor's or counselor's note or similar document.

Your Right to Reasonable Accommodation:

- You have the right to ask your employer for help or changes in your workplace to make sure you are safe at work. Your employer must work with you to see what changes can be made. Changes in the workplace may include putting in locks, changing your shift or phone number, transferring or reassigning you, or help with keeping a record of what happened to you. Your employer can ask you for a signed statement certifying that your request is for a proper purpose, and may also request proof showing your need for an accommodation. Your employer cannot tell your coworkers or anyone else about your request.

Your Right to Be Free from Retaliation and Discrimination:

Your employer cannot treat you differently or fire you because:

- You are a victim of domestic violence, sexual assault, or stalking.
- You asked for leave time to get help.
- You asked your employer for help or changes in the workplace to make sure you are safe at work.

You can file a complaint with the Labor Commissioner's Office against your employer if he/she retaliates or discriminates against you.

For more information, contact the California Labor Commissioner's Office. We can help you by phone at 213-897-6595, or you can find a local office on our website: www.dir.ca.gov/dlse/DistrictOffices.htm. If you do not speak English, we will provide an interpreter in your language at no cost to you. This Notice explains rights contained in California Labor Code sections 230 and 230.1. Employers may use this Notice or one substantially similar in content and clarity.

ACKNOWLEGDGMENT OF RECEIPT OF "RIGHTS OF VICTIMS OF DOMESTIC VIOLENCE, SEXUAL ASSAULT AND STALKING" (Labor Commissioner's Office – California Labor Code sections 230 and 230.1)

I acknowledge that I have received a copy of the form from the Labor Commissioner's Office noted above.

_____

Employee Print Name

_____

Employee Signature

_____

Date form was received