



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ. 07712
732-440-1122
www.theshorecenter.org

NEW HIRE PERSONNEL CHECKLIST

- ☐ Welcome Letter
- ☐ Criminal History/Fingerprinting
- ☐ Department of Education Background Checks/Fingerprinting
- ☐ *Form A- Authorization and Attestation of Applicant for Emergent School
Employment- sign, date and enter your phone number.
- ☐ *I-9 Form/Employment Eligibility Verification*- *only fill out page 1. Page 2 will be filled out in the office.*
- ☐ **MUST** Bring your Driver's license and Social Security Card **OR** Passport-
copies of your IDs will be made when you come into the office.
- ☐ *Oath of Allegiance/Verification of Accuracy*
- ☐ *Bayshore Jointure Commission IT Policy- you **MUST** sign and return page 6*
- ☐ Workmen's Compensation memo
- ☐ *Emergency Contact Information
- ☐ *New Employee Health Assessment Form
- ☐ *Tuberculosis Testing Affidavit

****all items MUST be returned to Personnel***



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ. 07712
732-440-1122
www.theshorecenter.org

Welcome to the Bayshore Jointure Commission. We are certain you will enjoy working with us.

As part of your employment the New Jersey statute requires that each new public school employee submit to a physical examination and provide the district with a complete health examination form as evidence of such physical examination (N.J.S.A. 18A:16-2et seq.) You will also submit to a Mantoux (TB) test unless you have been tested within the last six months or if you are a school employee transferring between school districts. In such case, [provide the Bayshore Jointure Commission a copy of your tuberculosis testing. Appropriate forms are attached for your use.

It is also mandated by the State of New Jersey that you be fingerprinted. Directions and forms for this procedure are attached.

Enclosed is the Bayshore Jointure Commission board Policy "Information Technology Usage Regulations" regarding an employee's use of email and other electronic communications systems, which are the property of Bayshore Jointure Commission. Please read the policy, ***sign and return.***

The Bayshore Jointure Commission permits all employees to participate in our tax sheltered investments program that has been established pursuant to Internal Revenue Services code 403 0b) (7). This plan permits you to make a tax deferred deduction from your pay and direct your investment to one of the five companies approved by the Bayshore Jointure Commission., The proceeds are taxable at retirement or withdrawal.

Return new hire packet to: Rowena Frankenbush, 100 Tornillo Way, Tinton Falls, NJ 07712 OR email it to rfrankenbush@theshorecenter.org.

IMPORTANT- PLEASE NOTE

These procedures are not an option and employment may not begin until these requirements are completed. If after 14 days you have not complied with the above directive, the position that you have applied for will re-open to other applicants.

Thank you for your attention in these matters.



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ. 07712
732-440-1122
www.theshorecenter.org

1. Access the Criminal History Review Unit's direct web address to begin the process. The web address is <http://www.nj.gov/education/educators/crimhist>. Click on "File Authorization and Make Electronic Payment for Criminal History Record Check."
2. **ARCHIVE-** Go to the above website and Click on "ARCHIVE APPLICATION REQUEST", follow the archive process. The archive process only requires that you complete the On-Line Authorization and Certification application and and pay the administrative fee, at the drop down menu select **COUNTY CODE: (25) Monmouth** and **DISTRICT CODE: (0225) Bayshore Jointure Commission**

YOU MUST ENTER BAYSHORE JOINTURE COMMISSION COUNTY CODE AND DISTRICT CODE OTHERWISE THE BACKGROUND CHECK WILL NOT QUALIFY.

3. **NEW APPLICANT:** Select Option #1: "New Administration Fee Request (New Applicants Only)". This screen displays four (4) options as to the job position(s) and employer. Please select the appropriate option and proceed to the next screen.
 - a. All Job Positions, except School Bus Drivers and Bus Aides, for Public Schools, Private Schools for Children with Disabilities and Charter Schools.
 - b. All School Bus Drivers and Bus Aides for Public Schools, Private Schools for Children with Disabilities, Charter Schools, Authorized School Bus Contractors.
 - c. All Job Positions, except School Bus Drivers and Bus Aides, for Non Public Schools
 - d. All School Bus Drivers and Bus Aides for Non Public Schools and Other Agencies.
4. Complete the requested applicant information. In the School Information box drop down menu select **COUNTY CODE: (25) Monmouth** and **DISTRICT CODE: (0225) Bayshore Jointure Commission**. Proceed to the Legal Certification. In order to continue with the ePayment process, read and accept the terms of the AA&C by checking the box.
5. Please complete the required payment information. There is a \$10.00 administrative fee for the department to process the request and issue an approval letter. There will be an additional \$1.00. Methods of payment are Visa, MasterCard, American Express or Discover credit cards. You **MUST** click the "Make Payment" button **ONLY ONE (1) time** to complete the transaction.
6. After completing the transaction, the Individual will be presented with three required steps:
 - a. View and/or print your New Administration Fee Payment Request confirmation page.
 - b. Complete and/or print your IdentGO NJ Universal Fingerprint Form
 - c. Click here to schedule your fingerprinting appointment with MorphoTrust

Select the first option "View and/or print your New Administration Fee Payment Request confirmation page" and print a copy of the receipt by clicking the print button in the upper right corner of the page and presenting a copy of the employing entity.



STATE OF NEW JERSEY

DEPARTMENT OF EDUCATION

A Memo from the New Jersey Department of Education

Date: February 6, 2020

To: Chief School Administrators, Charter School and Renaissance School Project Leads, Administrators of Private Schools for Students with Disabilities, Administrators of Nonpublic Schools

Route To: Personnel Responsible for Processing Background Checks, Authorized Vendors

From: Dr. Jamar E. Purnsley, Director
Office of Fiscal Accountability and Compliance

IDEMIA Service Code for New Applicants

Effective February 17, 2020, all new applicants for a criminal history background check will need a unique service code to schedule their fingerprint appointments with IDEMIA, the vendor that processes criminal history background checks. The six-character Service Code is used for uniquely identifying the Agency (ORI), Reason for Fingerprinting (RFP), Price, and other defining data for the transaction.

The use of the Service Code ensures that new applicants are being printed for the correct purpose and are not accidentally or incorrectly being processed for a service they don't need. IDEMIA's customer service call center representatives will not provide Service Codes to callers. The distribution of the Service Code is dependent on the hiring agency to provide the correct Service Code to the new applicants.

The following are Service Codes that have been provided to the Department of Education, Office of Student Protection:

Reason for Fingerprinting (Box 4 on the NJ Universal Fingerprint form)	Service Code
Public School Employment	2F1FB1
Nonpublic School Employment	2F19ZQ
School Bus Driver Employment	2F1GSH
School Board Member/Trustee	2FIGN4
DOE Volunteer	2F151N
DOE Volunteer Nonpublic	2F14XX

For additional information or clarification, please visit the New Jersey Department of Education's [Office of Student Protection](#) webpage and select the "Instructions" tab, or call the office at (609) 376-3999.

c: Members, State Board of Education
Lamont O. Repollet, Ed.D., Commissioner
NJDOE Staff
Statewide Parent Advocacy Network
Garden State Coalition of Schools
NJ LEE Group

Form A

Authorization and Attestation of Applicant for Emergent School Employment

This form shall only be used for those applicants who are being hired on an emergent basis who are not currently employed by any board of education or educational facility under the supervision of the Department of Education or by any contractor providing service to such school or facility.

I, _____, swear/affirm that I have not been convicted nor do I have any charges pending for the following crimes or offenses: any crime of the first or second degree; any crime bearing upon or involving sexual offense, child molestation; an offense involving the manufacture, transportation, sale, distribution, habitual use of a controlled dangerous substance or any violation involving drug paraphernalia, including hypodermic needles; any crime involving the use of force or the threat of force to or upon a person or property including, but not limited to, robbery, aggravated assault, stalking, kidnapping, arson, manslaughter and murder; any crime of possessing weapons; a third degree crime as set forth in Chapter 20 of Title 2C (theft); recklessly endangering another person, terroristic threats, criminal restraint, luring, enticing child into motor vehicle or isolated structure; causing or risking widespread injury or damage; criminal mischief, burglary, usury, threats and other improper influence, perjury and false swearing, resisting arrest, escape, bias intimidation, or a crime of the fourth degree involving a victim who is a minor; any conspiracy to commit or attempt to commit any of the crimes described in this act.

I have read and understand this statement. I am also aware that if I sign this statement and my criminal history record discloses a disqualifying crime or offense, I could be subject to prosecution.

I do hereby authorize the New Jersey State Department of Education, its agents and representatives, to submit fingerprint data pertaining to me to the Federal Bureau of Investigation and the New Jersey State Police, Bureau of Identification, for the purpose of obtaining criminal history record information as required by N.J.S.A. 18A:6-7.1 *et seq.*, N.J.S.A. 18A:39-17 *et seq.* or N.J.S.A. 18A:6-4.13 *et seq.*

Applicant Signature

Date

(_____)_____
Applicant Telephone Number



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

► **START HERE:** Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number [][] - [][] - [][][][]		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
-----------------------	---------------------------

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code



Employer Completes Next Page





Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
-------------------------------------	-------------------------	-------------------------	------	--------------------------------

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ (See instructions for exemptions)

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative		
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name		
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

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

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

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
----------------	-----------------	---------------------------------------

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
--	---------------------------	---

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

New Jersey State Department of Education
Office of Certification and Induction

OATH OF ALLEGIANCE / VERIFICATION OF ACCURACY

IMPORTANT: This form is to be completed by only those individuals who are U.S. citizens. See Section B below.

A. Basic Information *Please print your name as it appears on any documentation that you are required to submit*

Last Name First Name Middle Name or Initial

Street Address

City

State

Zip

Social Security Number

Date of Birth: Month

Day

Year

Tracking Number

Email Address

Phone Number Including Area Code

Are you applying for the New Charter School Certificates? Circle whichever applies YES NO

Are you a military veteran? Circle whichever applies YES NO

Endorsement Information. Please enter below the code and print the name of each endorsement for which you are applying.

Code

Name of Endorsement

B. Oath of Allegiance *Choose one of the following.*

Option I

I, _____ do solemnly swear, (or affirm) that I will support the Constitution of the United States and the Constitution of the State of New Jersey, and that I will bear true faith and allegiance to the same and to the governments established in the United States and in this State, under the authority of the people, so help me God.

Option II

I, _____ do solemnly swear, (or affirm) that I will support the Constitution of the United States and the Constitution of the State of New Jersey, and that I will bear true faith and allegiance to the same and to the governments established in the United States and in this State, under the authority of the people.

C. Certification *Failure to complete these items will result in rejection of the candidate's application for certification.*


Circle whichever applies

1. Have you ever been convicted of, pled guilty, no contest or *nolo contendere* to, or had adjudication withheld to a crime or offense, including DUI, in New Jersey or any other state or jurisdiction? If yes, complete and submit a Criminal/Offense Information Form. Yes No

2. Have you ever had an education or other professional certificate, license or credential revoked, suspended, invalidated or denied for cause in New Jersey or any other state or jurisdiction? * Yes No

3. Have you ever surrendered or relinquished an education or other professional certificate, license or credential in New Jersey or any other state or jurisdiction? * Yes No

4. Are you the subject of any pending action or proceedings against your education or other professional certificate(s), license(s) or credential(s) in New Jersey or any other state or jurisdiction? * Yes No

5. Have you ever resigned, retired or been dismissed or suspended from an education-related position in New Jersey or any other state or jurisdiction following allegations of misconduct? * Yes No	
6. Are you the subject of any civil, criminal or administrative investigation in New Jersey or any other state or jurisdiction? * Yes No	
* If any answer to Questions 2 through 6 is "yes," complete and submit an Additional Information For the Oath of Allegiance Form.	
D. Verification of Accuracy	
I certify that all statements and information provided herein are true and accurate.	
Applicant's Signature (in ink)	Date
Sworn and subscribed to before me this _____ day of _____, 20____	
Notary Seal	Notary Signature _____
Once completed, mail the form to:	<div style="text-align: center;">  <p> New Jersey State Department of Education Office of Certification and Induction P.O. Box 500 Trenton, New Jersey 08625-0500 Attention: Oath of Allegiance/Verification of Accuracy </p> </div>

BAYSHORE JOINTURE COMMISSION - THE SHORE CENTER

REGULATION		SECTION:PROGRAM	
TITLE:	EFFECTIVE DATE:	NO:	PAGES
Information Technology Usage Regulation	12/2013	R2361	1 of 6

Information Technology Usage Regulation

The e-mail and other electronic communications systems are to be used for business purposes only.

All information and communications created, received, saved or sent on the Commission's servers, workstations/laptops and any other electronic devices (including but not limited to PDA and cell phones) are the property of the Commission. This also includes any of the aforementioned created, received, saved or sent from host servers workstations/laptops or any other electronic device supplied by a host agency such as the Monmouth-Ocean Educational Services Commission.

Employee e-mail sent and received through the Commission's computers - including e-mail and internet search activity using third-party internet service providers (ISPs) - is subject to search and monitoring with or without notice, regardless of whether the Commission's systems are accessed in or out of the office, or whether the communications pass through the Commission's server. The Commission will periodically and randomly perform such monitoring of individual employee usage without cause to believe improper use is being undertaken, and in all circumstances where such cause exists.

OBLIGATION TO PRESERVE E-MAIL

The obligation to preserve e-mail shall be in accordance with all state regulations. While a user may delete an e-mail message, copies of the e-mail will still remain on servers and backup tapes and will be available to the Commission.

Only authorized encryption may be utilized. All passwords/encryption keys must be on file with the Monmouth-Ocean Educational Services Commission's Chief Technology Officer prior to their utilization.

All e-mails that are addressed to any person(s) outside of the Commission shall have a standard disclaimer at the bottom of the text, stating, "Nothing contained in this e-mail is intended to be an offer to commit the Commission to any purchase, sale, contract, or other course of action." This shall not apply to e-mails written by users who are authorized to enter into agreements on the Commission's behalf when the e-mail is part of an authorized course of business.

BAYSHORE JOINTURE COMMISSION - THE SHORE CENTER

REGULATION		SECTION:PROGRAM	
TITLE:	EFFECTIVE DATE:	NO:	PAGES
Information Technology Usage Regulation	12/2013	R2361	2 of 6

All e-mails that are addressed to any person(s) outside of the Commission shall clearly identify the user by full name and official title. The user's telephone number shall also be included.

Due to the potential for security breaches and the transmission of computer viruses, users shall exercise extreme caution in downloading and executing any files attached to e-mail. If the attachment is not clearly business related and/or expected from a known source, it should never be opened or executed. Such e-mails and attachments should be immediately brought to the attention of the Monmouth -ocean Educational ServicesCommission's Chief Technology Officer.

Users shall not subscribe to any e-mail lists that are not directly relevant to their assigned duties.

Information that is Sensitive or Confidential shall never be e-mailed to persons outside of the Commission unless all of the following conditions are met:

1. The e-mail transmission is expressly approved, in advance, by an authorized administrator.
2. The Sensitive or Confidential Information is encrypted.
3. The e-mail text includes a warning to the recipient that the material is Secret, Sensitive, or Confidential and is the property of the Commission.
4. The e-mail text contains a specific statement of why the recipient is receiving it, what they may do with the information, and who, if anyone, they may disclose it to.
5. A copy of the e-mail is permanently archived by the user. Each user is responsible for ensuring that the use of the Commission's e-mail system is consistent with this policy, any other applicable Commission policy, and appropriate business practices. E-mails shall not contain jokes (no matter how innocent or humorous), pornography, sexist, racist, defamatory or obscene remarks; anything of a commercial nature not pertaining to the Commission's business, anything of a political nature, or any other inappropriate remarks. Further, the e-mail system shall not be used for any purpose in violation of law or regulation.

The Commission's e-mail system shall not be utilized by users for any commercial or non-commercial activity that is not in furtherance of Commission's business. The prohibited activity includes solicitation for charitable contributions and sales of products from one user to another. "Chain Letter" e-mails shall not be created or forwarded. Messages sent to all users must have the expressed prior authorization of a manager.

Users shall carefully review all e-mail prior to sending it to ensure that its meaning is clear and not subject to interpretation. Humor and sarcasm can be easily misinterpreted in an e-mail and should be avoided. E-mail messages should be composed in a professional manner.

BAYSHORE JOINTURE COMMISSION - THE SHORE CENTER

REGULATION		SECTION:PROGRAM	
TITLE:	EFFECTIVE DATE:	NO:	PAGES
Information Technology Usage Regulation	12/2013	R2361	3 of 6

Comments that would be inappropriate in memoranda and letters are equally inappropriate in e-mails.

Unless given prior written approval, utilization of Commission owned computer assets to access any e-mail account of service by a user is expressly forbidden.

Passwords for the authorized user shall be assigned by the Monmouth-Ocean Educational Services Commission's Chief Technology Officer and will be changed on a regular basis. No user is permitted to change any password. Users shall not reveal their e-mail passwords to anyone. Excluding members of the Technology Department, users shall not utilize or access e-mail accounts belonging to any other user.

Violation of this policy shall result in disciplinary action up to and including action up to and including termination.

INTERNET USAGE

This regulation shall apply to anyone utilizing the Commission's Internet access systems, and any supplied by the host Monmouth-Ocean Educational Services Commission.

The Commission's Internet access is intended to further the business purposes of the Commission. All information created, sent or received via the Commission's computers, networks, Internet access and/or e-mail systems is the property of the Commission.

The Commission reserves the right to monitor, filter and/or review, at any time, all Internet utilization via the Commission's Internet access. The Commission further reserves the right to reveal any Internet access related information to any party that it deems appropriate. The use of encryption, the labeling of a communication as private, the deletion of a communication, or any other such process or action, shall not diminish the Commission's rights in any manner.

The Commission shall disclose Internet access information to any party that it may be required to by law or regulation. This may include law enforcement search warrants and discovery requests in civil litigation.

Users shall not access any material that is not directly relevant to their assigned duties.

BAYSHORE JOINTURE COMMISSION - THE SHORE CENTER

REGULATION		SECTION:PROGRAM	
TITLE:	EFFECTIVE DATE:	NO:	PAGES
Information Technology Usage Regulation	12/2013	R2361	4 of 6

Users shall not post any comments or statements on any web page or send any messages to Internet newsgroups.

Users shall not enter any Internet chat rooms or chat channels.

Due to the potential for security breaches, users shall not download software from the Internet unless prior written approval has been obtained from the Monmouth-Ocean Educational Services Commission's Chief Technology Officer.

Each user is responsible for ensuring that his or her use of the Commission's Internet access is consistent with this policy, any other applicable Commission policy, and appropriate business practices. Internet sites containing jokes (no matter how innocent or humorous), pornography, sexist, racist, defamatory or obscene material, pirated software, or any other inappropriate material shall not be accessed. Further, the Internet access system shall not be used for any purpose in violation of law or regulation.

The Commission's internet access shall not be utilized for any commercial or non-commercial activity that is not in furtherance of Commission business.

Users should be mindful that Internet sites they visit collect information about visitors. This information will link the user to the Commission. Users shall not visit any site that might in any way cause damage to the Commission's image, reputation, servers, workstations and network.

Users should be aware that much of the material available on the Internet is copyrighted or trademarked. Other than viewing publicly available material, users shall not use any material found on the Internet in any manner without first establishing that such use would not be in violation of a copyright or trademark.

Unless given prior written approval, utilization of Commission owned computer assets to access any e-mail account or service by a user is expressly forbidden.

Passwords for the authorized user shall be assigned by the Monmouth-Ocean Educational Services Commission's Chief Technology Officer and will be changed on a regular basis. No user is permitted to change any password. Users shall not reveal their passwords to anyone. Excluding members of the Monmouth-Ocean Educational Services Commission's Technology Department, users shall not utilize or access domain accounts, Internet accounts, and e-mail accounts belonging to any other user.

BAYSHORE JOINTURE COMMISSION - THE SHORE CENTER

REGULATION		SECTION:PROGRAM	
TITLE:	EFFECTIVE DATE:	NO:	PAGES
Information Technology Usage Regulation	12/2013	R2361	5 of 6

Violation of this regulation shall result in disciplinary action up to and including termination or any supplied by the host Monmouth-Ocean Educational Services Commission.

SOFTWARE CODE OF ETHICS

This regulation shall apply to anyone utilizing the Commission's Software Applications or any supplied by the host, the Monmouth-Ocean Educational Services Commission.

The Commission's Software is intended to further the business purposes of the Commission. Unauthorized duplication of copyrighted computer software violates the law and is contrary to the Commission's standards of conduct.

The Commission will neither engage in nor tolerate the making of or using of authorized software copies under any circumstances.

The Commission will provide licensed software to meet the legitimate software needs in a timely fashion and in sufficient quantities for the Commission's computers.

The Commission will comply with all license or purchase terms regulating the use of any software acquired or used.

The Commission will enforce strong internal controls to prevent the making of or using of unauthorized software copies, including effective measures to verify compliance with these standards and appropriate disciplinary measures for violation of these standards.

Violation of this regulation shall result in disciplinary action up to and including termination.

Network/Data Security

Only devices purchased and/or approved by the Chief Information Officer are permitted on the network. Unauthorized devices may not be connected to Commission systems/networks without written consent from the Monmouth-Ocean Services Commission's Chief Technology Officer. These devices are (but are not limited to):

- 1 – Personal computers/laptops
- 2 – USB flash drives
- 3 – Personal handheld devices

BAYSHORE JOINTURE COMMISSION - THE SHORE CENTER

REGULATION		SECTION:PROGRAM	
TITLE:	EFFECTIVE DATE:	NO:	PAGES
Information Technology Usage Regulation	12/2013	R2361	6 of 6

Commission owned computers used remotely (outside of the Commission network, therefore not protected by the Commission Firewall and anti-virus), will not be permitted on the internal network without being checked by the Information Technology department. Any device that is infected with a virus or has been compromised will be formatted (erased). The Information Technology department will reinstall Commission approved software only. Any additional software or personal documents will not be saved or reinstalled.

Please Print Name: _____

Employee's Signature: _____

Date: _____



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ. 07712
732-440-1122
www.theshorecenter.org

To: All Bayshore Staff

From: Christopher J. Mullins, Business Administrator

Date: July 1, 2015

Subject: Workmen's Compensation

All work related injuries are to be reported to QualCare: our managed Care provider for worker's compensation cases. While in the event of serious injury, the employee is permitted to seek emergency room care, all other medical care must be arranged first by calling QualCare at 1-800-425-3222. QualCare will notify the employee of the treating physician and the appointment time and date. Note that employees are not permitted to directly make an appointment with a treating physician or their own personal physician.

A supply of referral cards for Qualcare is enclosed. Please contact my office if you need additional cards. There is a separate card for prescription services through Jordan Reese.

In addition to the QualCare reporting; all work related injuries are to be immediately reported to the Central Office on the enclosed Accident Report form as soon as possible. In the event that an employee is injured by one of our students, the Violence, Vandalism and Substance Abuse (VV_SA) Incident Report Form is also required to be completed.

Please feel free to contact me with any questions. Thank you for your cooperation in this matter.



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ 07712
732 440-1122
www.theshorecenter.org

EMERGENCY CONTACT INFORMATION

Employee Name: _____ Date of Birth: _____

Address: _____

Email Address: (personal to be used for School Messenger) _____

School Messenger first contact # _____ School Messenger first contact # _____

EMERGENCY CONTACTS (MUST provide 2 contacts)

Name: _____ Name: _____

Address: _____ Address: _____

Cell Phone #: _____ Cell Phone #: _____

Home Phone #: _____ Home Phone #: _____



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ. 07712
732-440-1122
www.theshorecenter.org

NEW EMPLOYEE HEALTH ASSESSMENT FORM

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

Position: _____ Gender: ___ M ___ F ___ Glasses: Yes () No () Vision _____

Private Physician Name _____ Telephone # _____

Health History (Please Specify approximate age at onset and duration):

Allergies _____	Headaches (severe or migraine) _____
Arthritis _____	Heart Disease _____
Asthma _____	Hernia _____
Convulsive Disorders _____	High Blood Pressure _____
Diabetes _____	Hepatitis _____
Digestive Disorders _____	Kidney Disease _____
Drug Sensitivities _____	Neuromuscular Disorders _____
Ear Problems _____	Orthopedic Problems _____
Eye Problems _____	Psychological Disorders _____
Fainting Spells _____	Respiratory Problems _____
Rheumatic Fever _____	

Operations or Serious Injuries: _____

List any other significant health issues:

I certify that the above information is correct to the best of my knowledge and that I am physically and mentally able to perform all of the duties of my job description.

Date: _____ Signature of Employee: _____

Physical Examination

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____

Ears (Otoscopy) _____	Hernia _____
Eyes _____	Genito-Urinary _____
Lymph Glands _____	Orthopedic: _____
Thyroid _____	Structural _____
Nose _____	Posture _____
Throat _____	Feet _____
Teeth - Mouth _____	Skin _____
Heart _____	Nutrition _____
Lungs _____	Nervous System _____
Abdomen _____	Hearing _____

General Health: (Circle One) Good Fair Poor

I certify that this person is physically (Circle One: ABLE or UNABLE) to perform all the duties required by his/her job description.
Signature of Physician: _____ Date _____

Completed Form to be returned to the HR Department of The Shore Center.



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ 07712
732 440-1122
www.theshorecenter.org

TUBERCULOSIS TESTING AFFIDAVIT

I do hereby certify that I was tested for tuberculosis on:

DATE

Name: _____

Address: _____

Phone: _____

Applicants Signature: _____

Physician's Name: _____

Physician's Address: _____

Physician's Telephone Number: _____

Physician's Signature: _____

Date Mantoux Test Administered: _____

Results: _____



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ. 07712
732-440-1122
www.theshorecenter.org

BENEFITS, PAYROLL AND PENSION DOCUMENT CHECKLIST

- ☐ New Staff Data Form

PAYROLL

- ☐ W-4 (Federal)
- ☐ NJ W-4 (State)
- ☐ Direct Deposit Authorization form
- ☐ Copy of a voided check or Savings Deposit slip
- ☐ Doculivery Quick Start Guide- *note that you will need to "receive" your 1st paycheck before you can access your information.*

HEALTH/DENTAL/PENSION

- ☐ Health and Dental Benefit Information- *guide/directions on selecting or waiving your Health benefits.*
- ☐ NJDPB Explore Your Benefits/How To Access Your Benefits- *instructions on how to select or waive your health benefits*
- ☐ Horizon BCBSNJ Dental Programs form
- ☐ SEHBP REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT- *list of requirements for your dependents.*
- ☐ Pension Form- Report of Transfer/Multiple Enrollment Form- *instructions and form. Fill out ONLY if applicable.*
- ☐ Plan Connect Information- 403(b)



1/2023

NEW STAFF DATA Meeting Date: _____SS# _____ TRACKING # _____
EMAIL _____

ENROLLED IN PENSIONS: YES / NO PENSION CODE: TPAF PERS DCRP PENSION #: _____

LAST

MIDDLE

FIRST

PREFIX

MAIDEN

GENERATION SUFFIX

SEX

DOB

ADDRESS: _____

STREET

CITY

STATE

ZIP

TELEPHONE #

CELL #

ETHNICITY: _____

RACE: _____

LANGUAGE SPOKEN (language, other than English spoken fluently): _____

PREVIOUS EMPLOYER / TITLE/ LAST DATE AT FORMER POSITION / _____HIGHEST LEVEL OF EDUCATION
COMPLETED: _____

COLLEGE ATTENDED: _____

NATIONAL BOARD CERTIFIED: ☐ YES ☐ NODISTRICT IN WHICH STAFF MEMBER RECEIVED THEIR
PROVISIONAL TEACHER TRAINING: _____

YEARS OF TEACHING EXPERIENCE: _____

BJC

OTHER NJ

PUBLIC: _____

YEARS OF EXPERIENCE: _____

MILITARY

PUBLIC

STATE

CERTIFICATE(S) HELD: _____

(X)

SUBJECT AREA(S) LIST ALL CERTIFICATIONS

STANDARD		
PROVISIONAL		
CERTIFICATE OF ELIGIBILITY WITH ADVANCED STANDING		
CERTIFICATE OF ELIGIBILITY		

=====FOR OFFICE USE=====

CURRENT ASSIGNMENT:

Start Date: _____

Job Title: _____ Step: _____ UPC: _____ Assign Code: _____ Salary _____

Enrollment Complete: Pension _____ Health Benefits _____ Dental _____

Employee's Withholding Certificate

OMB No. 1545-0074

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.

2023

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) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> 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, other details, 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) Reserved for future use.
	(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; 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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate <input type="checkbox"/>

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits	If your total 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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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

Section references are to the Internal Revenue Code.

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, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2023 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 15, 2024.

Your privacy. 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).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds \$160,200 for a given individual.

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.

If you (and your spouse) have a total of only two jobs, you may 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. This step 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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2023 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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.

- 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 2023 itemized deductions (from Schedule A (Form 1040)). 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:

{	• \$27,700 if you're married filing jointly or a qualifying surviving spouse	}	2	\$ _____
	• \$20,800 if you're head of household				
	• \$13,850 if you're single or married filing separately				

- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. 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)). 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 territories 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 Surviving Spouse

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	\$0	\$850	\$850	\$1,000	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,870
\$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
\$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
\$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
\$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
\$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
\$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
\$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
\$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
\$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
\$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
\$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
\$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
\$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
\$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
\$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
\$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	\$310	\$890	\$1,020	\$1,020	\$1,020	\$1,860	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040
\$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
\$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
\$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
\$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
\$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
\$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
\$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
\$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
\$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
\$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
\$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
\$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
\$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	\$620	\$860	\$1,020	\$1,020	\$1,020	\$1,020	\$1,650	\$1,870	\$1,870	\$1,890	\$2,040
\$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
\$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
\$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
\$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
\$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
\$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
\$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
\$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
\$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
\$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
\$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
\$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
\$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

State of New Jersey – Division of Taxation
Employee's Withholding Allowance Certificate

1. SS#			2. Filing Status: (Check only one box)		
Name			1. <input type="checkbox"/> Single		
Address			2. <input type="checkbox"/> Married/Civil Union Couple Joint		
City			3. <input type="checkbox"/> Married/Civil Union Partner Separate		
State		Zip	4. <input type="checkbox"/> Head of Household		
			5. <input type="checkbox"/> Qualifying Widow(er)/Surviving Civil Union Partner		
3. If you have chosen to use the chart from instruction A, enter the appropriate letter here.....					3.
4. Total number of allowances you are claiming (see instructions).....					4.
5. Additional amount you want deducted from each pay					5. \$
6. I claim exemption from withholding of NJ Gross Income Tax and I certify that I have met the conditions in the instructions of the NJ-W4. If you have met the conditions, enter "EXEMPT" here.....					6.
7. Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or entitled to claim exempt status.					
Employee's Signature			Date		
Employer's Name and Address			Employer Identification Number		

BASIC INSTRUCTIONS

- Line 1 Enter your name, address, and Social Security number in the spaces provided.
- Line 2 Check the box that indicates your filing status. If you checked Box 1 (Single) or Box 3 (Married/Civil Union Partner Separate) you will be withheld at Rate A.
Note: If you have checked Box 2 (Married/Civil Union Couple Joint), Box 4 (Head of Household) or Box 5 (Qualifying Widow(er) Surviving Civil Union Partner) and either your spouse/civil union partner works or you have more than one job or more than one source of income and the combined total of all wages is greater than \$50,000, see instruction A below. If you do not complete Line 3, you will be withheld at Rate B.
- Line 3 If you have chosen to use the wage chart below, enter the appropriate letter.
- Line 4 Enter the number of allowances you are claiming. Entering a number on this line will decrease the amount of withholding and could result in an underpayment on your return.
- Line 5 Enter the amount of additional withholdings you want deducted from each pay.
- Line 6 Enter "EXEMPT" to indicate that you are exempt from New Jersey Gross Income Tax Withholdings, if you meet one of the following conditions:
- Your filing status is **SINGLE** or **MARRIED/CIVIL UNION PARTNER SEPARATE** and your wages plus your taxable nonwage income will be \$10,000 or less for the current year.
 - Your filing status is **MARRIED/CIVIL UNION COUPLE JOINT**, and your wages combined with your spouse's/civil union partner's wages plus your taxable nonwage income will be \$20,000 or less for the current year.
 - Your filing status is **HEAD OF HOUSEHOLD** or **QUALIFYING WIDOW(ER)/SURVIVING CIVIL UNION PARTNER** and your wages plus your taxable nonwage income will be \$20,000 or less for the current year.
- Your exemption is good for ONE year only. You must complete and submit a form each year certifying you have no New Jersey Gross Income Tax liability and claim exemption from withholding. If you have questions about eligibility, filing status, withholding rates, etc. when completing this form, call the Division of Taxation's Customer Service Center at (609) 292-6400.

Instruction A - Wage Chart

This chart is designed to increase withholdings on your wages, if these wages will be taxed at a higher rate due to inclusion of other wages or income on your NJ-1040 return. **It is not intended to provide withholding for other income or wages.** If you need additional withholdings for other income or wages, use Line 5 on the NJ-W4. This Wage Chart applies to taxpayers who are married/civil union couple filing jointly, heads of households, or qualifying widow(er)/surviving civil union partner. **Single individuals or married/civil union partners filing separate returns do not need to use this chart.** If you have indicated filing status #2, 4 or 5 on the above NJ-W4 and your taxable income is greater than \$50,000, you should strongly consider using the Wage Chart. (See the Rate Tables on the reverse side to estimate your withholding amount.)

HOW TO USE THE CHART

- 1) Find the amount of your wages in the left-hand column.
- 2) Find the amount of the total for all other wages (including your spouse's/civil union partner's wages) along the top row.
- 3) Follow along the row that contains your wages until you come to the column that contains the other wages.
- 4) This meeting point indicates the Withholding Table that best reflects your income situation.
- 5) If you have chosen this method, enter the "letter" of the withholding rate table on Line 3 of the NJ-W4.

NOTE: If your income situation substantially increases (or decreases) in the future, you should resubmit a revised NJ-W4 to your employer.

WAGE CHART

Total of All Other Wages		0 10,000	10,001 20,000	20,001 30,000	30,001 40,000	40,001 50,000	50,001 60,000	60,001 70,000	70,001 80,000	80,001 90,000	OVER 90,000
Y O U R W A G E S	0 10,000	B	B	B	B	B	B	B	B	B	B
	10,001 20,000	B	B	B	B	C	C	C	C	C	C
	20,001 30,000	B	B	B	A	A	D	D	D	D	D
	30,001 40,000	B	B	A	A	A	A	A	E	E	E
	40,001 50,000	B	C	A	A	A	A	A	E	E	E
	50,001 60,000	B	C	D	A	A	A	E	E	E	E
	60,001 70,000	B	C	D	A	A	E	E	E	E	E
	70,001 80,000	B	C	D	E	E	E	E	E	E	E
	80,001 90,000	B	C	D	E	E	E	E	E	E	E
	OVER 90,000	B	C	D	E	E	E	E	E	E	E

RATE TABLES FOR WAGE CHART

The rate tables listed below correspond to the letters in the Wage Chart on the front page. Use these to estimate the amount of withholding that will occur if you choose to use the wage chart. Compare this to your estimated income tax liability for your New Jersey Income Tax return to see if this is the correct amount of withholding that you should have.

RATE "A"

WEEKLY PAYROLL PERIOD (Allowance \$19.20)					ANNUAL PAYROLL PERIOD (Allowance \$1,000)				
If the amount of taxable wages is:		The amount of income tax to be withheld is:			If the amount of taxable wages is:		The amount of income tax to be withheld is:		
Over	But Not Over		Of Excess Over		Over	But Not Over		Of Excess Over	
\$ 0	\$ 385		1.5%	\$ 0	\$ 0	\$ 20,000		1.5%	\$ 0
\$ 385	\$ 673	\$ 5.77 +	2.0%	\$ 385	\$ 20,000	\$ 35,000	\$ 300.00 +	2.0%	\$ 20,000
\$ 673	\$ 769	\$ 11.54 +	3.9%	\$ 673	\$ 35,000	\$ 40,000	\$ 600.00 +	3.9%	\$ 35,000
\$ 769	\$ 1,442	\$ 15.29 +	6.1%	\$ 769	\$ 40,000	\$ 75,000	\$ 795.00 +	6.1%	\$ 40,000
\$ 1,442	\$ 9,615	\$ 56.35 +	7.0%	\$ 1,442	\$ 75,000	\$ 500,000	\$ 2,930.00 +	7.0%	\$ 75,000
\$ 9,615	\$ 19,231	\$ 628.46 +	9.9%	\$ 9,615	\$ 500,000	\$ 1,000,000	\$ 32,680.00 +	9.9%	\$ 500,000
\$ 19,231		\$ 1,580.38 +	11.8%	\$ 19,231	\$ 1,000,000	over	\$ 82,180.00 +	11.8%	\$ 1,000,000

RATE "B"

WEEKLY PAYROLL PERIOD (Allowance \$19.20)					ANNUAL PAYROLL PERIOD (Allowance \$1,000)				
If the amount of taxable wages is:		The amount of income tax to be withheld is:			If the amount of taxable wages is:		The amount of income tax to be withheld is:		
Over	But Not Over		Of Excess Over		Over	But Not Over		Of Excess Over	
\$ 0	\$ 385		1.5%	\$ 0	\$ 0	\$ 20,000		1.5%	\$ 0
\$ 385	\$ 962	\$ 5.77 +	2.0%	\$ 385	\$ 20,000	\$ 50,000	\$ 300.00 +	2.0%	\$ 20,000
\$ 962	\$ 1,346	\$ 17.31 +	2.7%	\$ 962	\$ 50,000	\$ 70,000	\$ 900.00 +	2.7%	\$ 50,000
\$ 1,346	\$ 1,538	\$ 27.69 +	3.9%	\$ 1,346	\$ 70,000	\$ 80,000	\$ 1,440.00 +	3.9%	\$ 70,000
\$ 1,538	\$ 2,885	\$ 35.19 +	6.1%	\$ 1,538	\$ 80,000	\$ 150,000	\$ 1,830.00 +	6.1%	\$ 80,000
\$ 2,885	\$ 9,615	\$ 117.31 +	7.0%	\$ 2,885	\$ 150,000	\$ 500,000	\$ 6,100.00 +	7.0%	\$ 150,000
\$ 9,615	\$ 19,231	\$ 588.46 +	9.9%	\$ 9,615	\$ 500,000	\$ 1,000,000	\$ 30,600.00 +	9.9%	\$ 500,000
\$ 19,231		\$ 1,540.38 +	11.8%	\$ 19,231	\$ 1,000,000		\$ 80,100.00 +	11.8%	\$ 1,000,000

RATE "C"

WEEKLY PAYROLL PERIOD (Allowance \$19.20)					ANNUAL PAYROLL PERIOD (Allowance \$1,000)				
If the amount of taxable wages is:		The amount of income tax to be withheld is:			If the amount of taxable wages is:		The amount of income tax to be withheld is:		
Over	But Not Over		Of Excess Over		Over	But Not Over		Of Excess Over	
\$ 0	\$ 385		1.5%	\$ 0	\$ 0	\$ 20,000		1.5%	\$ 0
\$ 385	\$ 769	\$ 5.77 +	2.3%	\$ 385	\$ 20,000	\$ 40,000	\$ 300.00 +	2.3%	\$ 20,000
\$ 769	\$ 962	\$ 14.62 +	2.8%	\$ 769	\$ 40,000	\$ 50,000	\$ 760.00 +	2.8%	\$ 40,000
\$ 962	\$ 1,154	\$ 20.00 +	3.5%	\$ 962	\$ 50,000	\$ 60,000	\$ 1,040.00 +	3.5%	\$ 50,000
\$ 1,154	\$ 2,885	\$ 26.73 +	5.6%	\$ 1,154	\$ 60,000	\$ 150,000	\$ 1,390.00 +	5.6%	\$ 60,000
\$ 2,885	\$ 9,615	\$ 123.65 +	6.6%	\$ 2,885	\$ 150,000	\$ 500,000	\$ 6,430.00 +	6.6%	\$ 150,000
\$ 9,615	\$ 19,231	\$ 567.88 +	9.9%	\$ 9,615	\$ 500,000	\$ 1,000,000	\$ 29,530.00 +	9.9%	\$ 500,000
\$ 19,231		\$ 1,519.81 +	11.8%	\$ 19,231	\$ 1,000,000		\$ 79,030.00 +	11.8%	\$ 1,000,000

RATE "D"

WEEKLY PAYROLL PERIOD (Allowance \$19.20)					ANNUAL PAYROLL PERIOD (Allowance \$1,000)				
If the amount of taxable wages is:		The amount of income tax to be withheld is:			If the amount of taxable wages is:		The amount of income tax to be withheld is:		
Over	But Not Over		Of Excess Over		Over	But Not Over		Of Excess Over	
\$ 0	\$ 385		1.5%	\$ 0	\$ 0	\$ 20,000		1.5%	\$ 0
\$ 385	\$ 769	\$ 5.77 +	2.7%	\$ 385	\$ 20,000	\$ 40,000	\$ 300.00 +	2.7%	\$ 20,000
\$ 769	\$ 962	\$ 16.15 +	3.4%	\$ 769	\$ 40,000	\$ 50,000	\$ 840.00 +	3.4%	\$ 40,000
\$ 962	\$ 1,154	\$ 22.69 +	4.3%	\$ 962	\$ 50,000	\$ 60,000	\$ 1,180.00 +	4.3%	\$ 50,000
\$ 1,154	\$ 2,885	\$ 30.96 +	5.6%	\$ 1,154	\$ 60,000	\$ 150,000	\$ 1,610.00 +	5.6%	\$ 60,000
\$ 2,885	\$ 9,615	\$ 127.88 +	6.5%	\$ 2,885	\$ 150,000	\$ 500,000	\$ 6,650.00 +	6.5%	\$ 150,000
\$ 9,615	\$ 19,231	\$ 565.38 +	9.9%	\$ 9,615	\$ 500,000	\$ 1,000,000	\$ 29,400.00 +	9.9%	\$ 500,000
\$ 19,231		\$ 1,517.31 +	11.8%	\$ 19,231	\$ 1,000,000		\$ 78,900.00 +	11.8%	\$ 1,000,000

RATE "E"

WEEKLY PAYROLL PERIOD (Allowance \$19.20)					ANNUAL PAYROLL PERIOD (Allowance \$1,000)				
If the amount of taxable wages is:		The amount of income tax to be withheld is:			If the amount of taxable wages is:		The amount of income tax to be withheld is:		
Over	But Not Over		Of Excess Over		Over	But Not Over		Of Excess Over	
\$ 0	\$ 385		1.5%	\$ 0	\$ 0	\$ 20,000		1.5%	\$ 0
\$ 385	\$ 673	\$ 5.77 +	2.0%	\$ 385	\$ 20,000	\$ 35,000	\$ 300.00 +	2.0%	\$ 20,000
\$ 673	\$ 1,923	\$ 11.54 +	5.8%	\$ 673	\$ 35,000	\$ 100,000	\$ 600.00 +	5.8%	\$ 35,000
\$ 1,923	\$ 9,615	\$ 84.04 +	6.5%	\$ 1,923	\$ 100,000	\$ 500,000	\$ 4,370.00 +	6.5%	\$ 100,000
\$ 9,615	\$ 19,231	\$ 584.04 +	9.9%	\$ 9,615	\$ 500,000	\$ 1,000,000	\$ 30,370.00 +	9.9%	\$ 500,000
\$ 19,231		\$ 1,535.96 +	11.8%	\$ 19,231	\$ 1,000,000		\$ 79,870.00 +	11.8%	\$ 1,000,000



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ. 07712
732-440-1122 www.theshorecenter.org

DIRECT DEPOSIT AUTHORIZATION FORM

Employee Name: _____ Effective Payroll Date*: _____

***Please submit your change request ten (10) calendar days before the 15th or the 30th payroll dates to allow for processing.**

Employee Job Title: _____ Social Security Number: _____

ACCOUNT #1: Bank Name: _____

☐ Checking

☐ Savings

Account #: _____ Bank Routing #: _____

DEPOSIT: Entire Check: _____ Dollar Amount: \$ _____ or Percentage _____ %

Choose **ONLY** one of the above.

☐ Voided check(NO checking deposit slips)

☐ Savings Deposit Slip

Please check one of the above. A voided check **OR** a savings deposit slip is required for verification.

ACCOUNT #2: Bank Name: _____

☐ Checking

☐ Savings

Account #: _____ Bank Routing #: _____

DEPOSIT: Entire Check: _____ Dollar Amount: \$ _____ or Percentage _____ %

Choose **ONLY** one of the above.

☐ Voided check(NO checking deposit slips)

☐ Savings Deposit Slip

Please check one of the above. A voided check **OR** a savings deposit slip is required for verification.

Any amount not specified to be deposited into Account #2 will be automatically deposited into Account #1.

I hereby authorize The Shore Center to direct deposit my pay to the bank(s) and account(s) indicated herein. I have attached a voided check (no checking deposit slips) or savings deposit slip for each account, and included the correct bank routing and account numbers in the areas provided.

Signature: _____ Date: _____

DOCULIVERY

Quick-Start Guide

This guide provides you with the basic quick-start information needed to log in and access your electronic documents in no time at all. The instructions below highlight the steps for logging into the Doculivery system with a unique User ID and Password to access your online pay stubs and setup notification options with just a few quick clicks!

Getting Started

1. Point your internet browser to the following url:

www.Doculivery.com/Systems3000-Bayshore

2. Enter your User ID. **1**

Your USER ID is:

Your last name plus the last four digits of your SSN.

3. Enter your initial Password. **2**
You will be required to change your password upon initial log in.

Your initial PASSWORD is:

The last four digits of your SSN.

4. Click the Log In button. **3**

5. Once you have logged in and changed your password, please make a note of your new password for future reference.

6. Once logged in, you will see the main screen which is organized by tabs. Click on the Pay Stubs tab **4** to see a list of all pay dates for which you have a pay stub. To see the entire pay stub for a particular date click on the view icon in the Click To View column on the left side of the screen. **5**


PLEASE LOG-IN TO THE DOCULIVERY SYSTEM.

User ID help information will appear here
when you visit the url noted in step one.







User ID: **1**

Password help information will appear here
when you visit the url noted in step one.

Password: **2**

3


4 Pay Stubs
Messages
Manage Your Account

CLICK TO VIEW	PAY DATE	PAY BEGIN DATE	PAY END DATE
	07/24/2006	07/19/2006	07/21/2006
	07/19/2006	06/26/2006	07/03/2006
5 	06/26/2006	06/19/2006	06/23/2006
	06/19/2006	05/29/2006	06/09/2006
	05/29/2006	05/15/2006	05/26/2006
	05/15/2006	04/17/2006	04/28/2006

CURRENT NOTIFICATION OPTIONS

Email my new paystub [tyleen@nlpay.com] (as HTML). Remove

Email my new paystub [tyleen@nlpay.com] (as HTML). Remove

Text Message of Categories by sending a text message to the phone number: (013) 222-0333 (AT&T) Remove

Email my new paystub (123@abc.com) (as HTML). Remove

Notify me when my paystub is delivered by sending a text message to the phone number: (260) 437-5979 (VERIZON WIRELESS) Remove

Notify me when my paystub is delivered by sending an email to the email address: test@test.com Remove

6 Add Another Email Delivery Option ☐

Add Another Email Notification ☐

Add Another Text Message Notification ☐

Add Detailed Text Messaging ☐

Setting Up Notification Options

1. Click on the Pay Stubs tab **4**. On the right side of the screen, select the appropriate bar **6** to setup email or text message notifications.



Bayshore Jointure Commission
The Shore Center for Students with Autism
100 Tornillo Way
Tinton Falls, NJ 07712
732 440-1122
www.theshorecenter.org

HEALTH AND DENTAL BENEFIT INFORMATION

- You **MUST** select your Health Benefits in Benefitsolver.
- You will receive an email notification from Tracy Petrino, Paymaster/Health Benefits Administrator- *see sample email notification below.*
- Follow the directions on the "NJDPB Explore Your Benefits" and "How to access your benefits" instruction guide. These are included in your New Hire packet **AND** are attached to Ms.Petrino's email.
- For Dental Benefits *if applicable*, You **MUST** fill out the:
ENROLLMENT/CHANGE REQUEST - Horizon BCBSNJ Dental Programs form
- For additional questions regarding benefits, payroll and pensions please contact:
Tracy Petrino
Paymaster/Health Benefits Administrator
732 264-8401 ext. 1110
tpetrino@theshorecenter.org

SAMPLE EMAIL NOTIFICATION

Good afternoon.

As a new employee you must select your Health Benefits in Benefitsolver. See attached.

You must complete the enrollment process in Benefitsolver even if you are waiving benefits.

Please let me know if you have any questions.

Thanks.

Tracy

Tracy Petrino
Bayshore Jointure Commission
Paymaster / Health Benefits Administrator
732-264-8401 ext. 1110
tpetrino@theshorecenter.org

Businessolver
PO Box 887
Ames, IA 50010



40254_SONJE



Important News! New Ways to Access Your Health Benefits Online

The New Jersey School Employees' Health Benefits Program (SEHBP) and the New Jersey Division of Pensions & Benefits (NJDPB) are excited to announce a new portal, Benefitsolver, for accessing all your health benefit enrollment needs, including the fall Annual Open Enrollment period.

What You Need to Know

Through Benefitsolver, you can access information about your health benefits and complete your enrollment applications online. You'll be able to add new dependents and upload documentation right to the website, as well as confirm your coverage and get links to all your health benefit vendors. You'll have multiple ways to access the new portal including 24/7 access via a new mobile app.

What You Need to Do

Beginning June 1, 2021, you will be able to log in to review your health benefit information. *

- Navigate to: <http://mynjbenefitshub.nj.gov>
 - a. Click Register
 - b. Enter Social Security Number and Date of Birth
 - c. Enter Company Key = SHBP/SEHBP
 - d. Click Continue

Once you're on the Benefitsolver website, you will be asked to enter your personal email address so we can keep in touch with you – send you reminders, confirmations of enrollment, and important information about how to get the most out of your benefits.

From there, download the MyChoice Mobile App so you can have your benefits at your fingertips – even take a picture of your insurance cards and store them in the app, so you're never without them!

Don't worry, your personal information is safe with us, we don't share this with outside vendors.

Please see the enclosed flyer with detailed information about how you can download the mobile app and have all your benefits information at your fingertips.

If you have questions regarding your benefits, please see your employer or call the NJDPB Office of Client Services at 609-292-7524.

If you have trouble accessing the Benefitsolver website, please see your Human Resources Representative.

**You may also be able to access Benefitsolver via your myNewJersey account at <https://www.state.nj.us/treasury/pensions/>*

We look forward to assisting you with your health benefits in 2021 and beyond.

Enclosure

How to access your benefits



Welcome

UserName *

First time here?

Register to create your user name and password.

Register

Case sensitive

Password *

Case sensitive

Login >

Forgot your user name or password?

HOW TO LOGIN:

Navigate to: <http://mynjbenefitshub.nj.gov> and click Register.

Enter Social Security Number and Date of Birth.

Company Key = SHBP/SEHBP

LET'S KEEP IN TOUCH

You'll be asked to provide an email address so we can send you the latest information on your benefits, including Annual Open Enrollment information.

EXPLORE YOUR SITE

Explore the site to learn about your benefits. You'll find lots of helpful information in the **Reference Center**.

REVIEW YOUR BENEFITS

Click the **Benefit Summary** button on the home page to review your personal information, your covered dependents, and your medical, prescription, and dental plan details.

FOR HELP

Sofia, your personal benefits assistant, can answer questions and guide you through the site.

Contact your local Human Resources Department, Benefits Administrator, or your Certifying Officer for additional assistance.

Making Healthy Happen Together

Hello, I'm Sofia. What can I help you with today?

Sofia

Welcome, Kendrial

Profile

Benefit Summary

Personal Documents

What You Need To Know

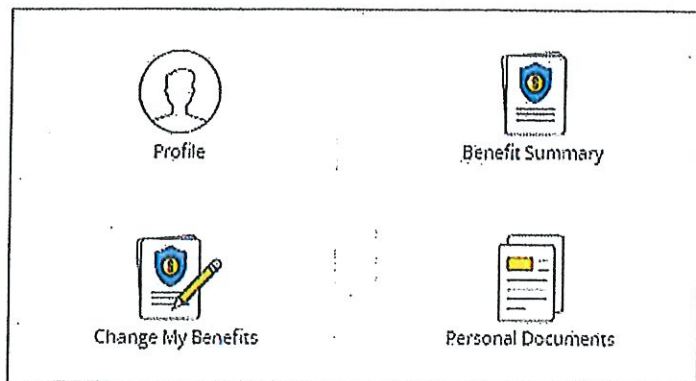
Welcome to your online benefits portal. You can access all of your medical and dental enrollment information right here, as well as make any changes to your benefits due to a life event.

Your next opportunity to make a change to your benefits program will be in the fall. Be on the lookout for mailings and emails announcing Annual Enrollment and any changes to your benefits or your costs of coverage.

We want to help you maximize your benefits, so that you get the most out of the SHBP/SEHBP. Take advantage of all our site has to offer you!

Hello, I'm Sofia. What can I help you with today?

Sofia



CHANGE YOUR BENEFITS OR INFORMATION

To report a Qualifying Life Event, such as a Marriage or Birth/Adoption, start by clicking the Change My Benefits button.

Select your Life Event from the Life Event box and enter the effective date of the change.

To change your contact information, start by clicking the Change My Benefits button.

Select Basic Info and click Address and Phone Number Information Change. Enter the effective date of the change.

Search Reasons for Change

Select the reason for change that applies and enter the date of the event.

<p>▼ BASIC INFO</p> <p>Address Change of Address Change of Employment</p> <p>Address and Phone Number/Contact Change</p>	<p>▼ LIFE EVENT</p> <p>Birth/Adoption Divorce Death of Dependents Disability Group Coverage on Demand Please Enter Today's Date Loss of Coverage Elsewhere Loss of Coverage Elsewhere Marriage Retirement/IRA Updating Dependents Demographic Information Only</p>
--	--

CONTINUE YOUR CHANGE

The next set of screens will walk you through your enrollment step by step, showing you the available options relevant to the change you'd like to make.

Make sure your personal information, elections, and dependents are accurate, then click **Looks Good!**

To complete your transaction, click **Approve**. On the Confirmation screen, click **I Agree**.

If you've added new dependents, you will be prompted to provide supporting documentation. Your employer will verify all uploaded documents before your dependent is approved.

When your enrollment is complete, you will receive a confirmation number and can print your **Benefit Summary** for your records.

Transaction Complete

Your information has been submitted.
Select Home to return to your benefits home page or Log Out to end this session.

Confirmation Number
123-53-04-4539

Thank You

AFTER YOU ENROLL

Return to the Home page to check for any additional tasks needed to complete your enrollment. View or download your Benefit Summary, and download the **MyChoice Mobile App**.

Visit this site anytime you want to learn more about your benefits or even search for a new provider and Book an Appointment using **Amino!**

To Do

New Hire Enrollment - Pending Dependent Verification

Upload Documents

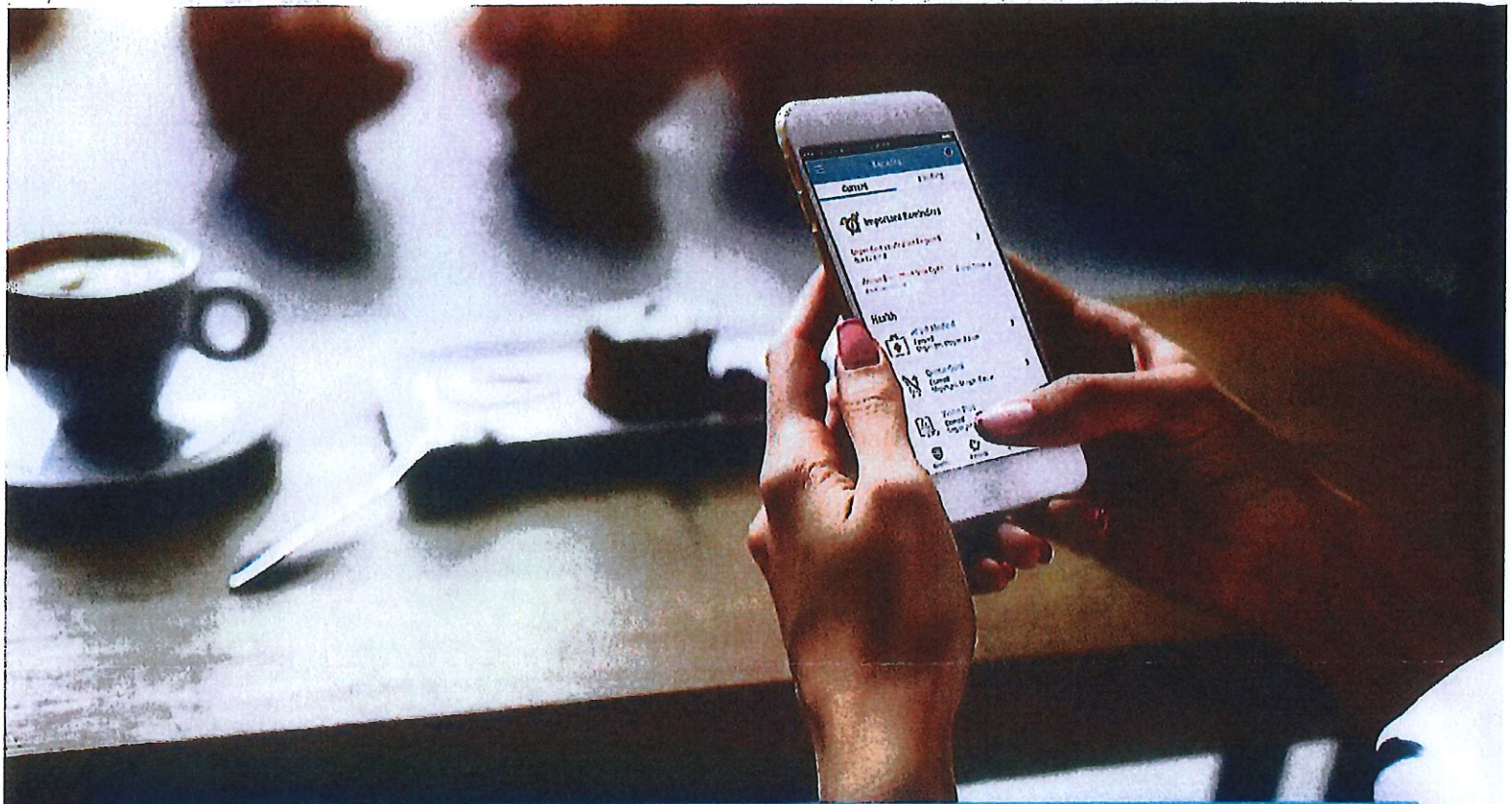
my choice Mobile App

MyChoice Mobile App

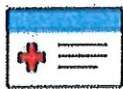
- Quick access to benefit details
- Store your ID Cards

Get Access Code





Access **YOUR** benefits where **YOU** want



Never again be stuck at the doctor's office without your ID card.



Getting married or having a baby?
Upload your dependents here.

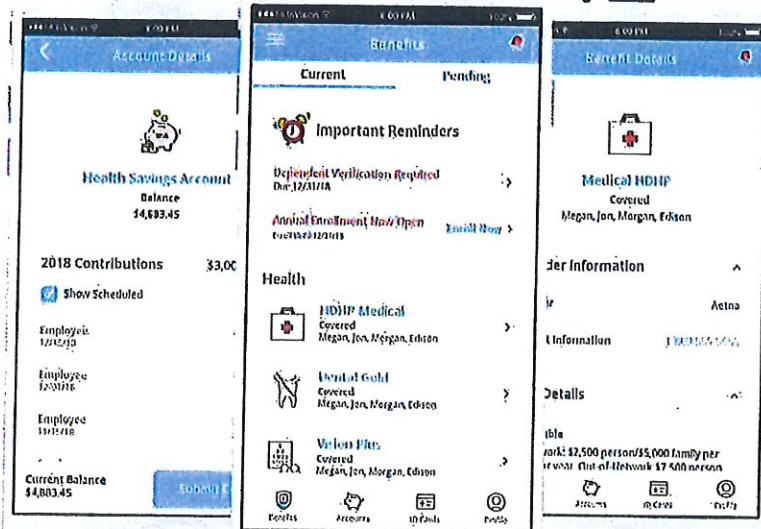


Find out if your benefits cover that
upcoming surgery.



Call or chat with a Member Services
Advocate at anytime, day or night.





All your benefits in
the palm of your hand

All of your benefits information on the MyChoiceSM Mobile App!

This is one app you will definitely want to download to make your life much easier. Here are some of the valuable features the MyChoice app offers you:



Current Benefits – View your current medical, dental, vision plans, medical savings accounts, voluntary and supplement benefits.



Beneficiaries – View your listed primary and contingent beneficiaries for applicable insurance policies.



Messages – Stay on top of important deadlines, send and receive important documentation in regards to your benefits, such as dependent verification and EOI.



ID Card – View your virtual card. Keep all of your Medical ID information at the tip of your fingers!



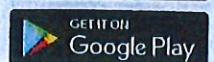
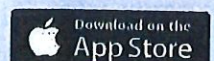
Contact Info – Easily contact a representative for general questions about your benefits, benefits enrollment, life events or required documentation.

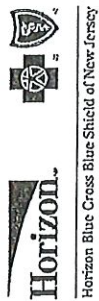
You can do all this with a few taps of a finger, plus much more!



Download the app now!

Once you download it, log into **Benefitsolver** to receive your access code.





ENROLLMENT/CHANGE REQUEST

Horizon BCBSNJ Dental Programs

P.O. Box 1710
Newark, NJ 07101-1938
www.HorizonBlue.com/dental
1-800-4DENTAL

Group Information - To Be Completed by Employer

1-800-4DENTAL

Horizon Blue Cross Blue Shield of New Jersey

A. Type of Activity - To Be Completed by Employer Refer to instructions on back before completing this form. Print clearly.

1. Enrollment		2. Change - Check all that apply:		3. Remove or Terminate - Check all that apply:		4. Continuation of Coverage, i.e., COBRA, State, Total Disability	
<input type="checkbox"/> New Subscriber	<input type="checkbox"/> Add Spouse	<input type="checkbox"/> Add Spouse	<input type="checkbox"/> Add Spouse/Domestic Partner/Civil Union Partner	<input type="checkbox"/> Remove Spouse/Domestic Partner/Civil Union Partner	<input type="checkbox"/> Remove Dependent Child	<input type="checkbox"/> Employee Withdrawal/Termination	<input type="checkbox"/> Total Disability
Effective Date	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Civil Union Partner	<input type="checkbox"/> Civil Union Partner	<input type="checkbox"/> Remove Dependent Child	<input type="checkbox"/> Employee must be enrolled for spouse/domestic partner/civil union partner	Not all options are available. Contact Employer for available options.
Date of Hire	<input type="checkbox"/> Add Dependent Child	<input type="checkbox"/> Add Dependent Child	<input type="checkbox"/> Add Dependent Child	<input type="checkbox"/> Add Dependent Child	<input type="checkbox"/> Add Dependent Child	<input type="checkbox"/> Note: Employee must be enrolled for spouse/domestic partner/civil union partner	Coverage For <input type="checkbox"/> Employee <input type="checkbox"/> Dependents
	<input type="checkbox"/> Name Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Note: Employee must be enrolled for spouse/domestic partner/civil union partner	Length of Continuation: <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos* <input type="checkbox"/> 36 mos
	<input type="checkbox"/> Change Plan	<input type="checkbox"/> Change Plan	<input type="checkbox"/> Change Plan	<input type="checkbox"/> Change Plan	<input type="checkbox"/> Change Plan	<input type="checkbox"/> Note: Employee must be enrolled for spouse/domestic partner/civil union partner	Date of Loss of Coverage: / /
	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Note: Employee must be enrolled for spouse/domestic partner/civil union partner	Date of Qualifying Event: / /
	<input type="checkbox"/> Add/Change Dentist Office ID	<input type="checkbox"/> Add/Change Dentist Office ID	<input type="checkbox"/> Add/Change Dentist Office ID	<input type="checkbox"/> Add/Change Dentist Office ID	<input type="checkbox"/> Add/Change Dentist Office ID	<input type="checkbox"/> Note: Employee must be enrolled for spouse/domestic partner/civil union partner	*Attach proof of disability

B. Employee Information - Complete Sections B - G		C. Plan Option - Your selection must be offered by your employer.	
Social Security Number	Last Name, First Name, M.I.	Horizon BCBSNJ	Horizon Healthcare Dental
Home Address	Apt. No., City, State	<input type="checkbox"/> Horizon Dental Traditional	<input type="checkbox"/> Horizon Dental Choice
Employer Name	Work Telephone	<input type="checkbox"/> Horizon Dental Option	<input type="checkbox"/> Horizon TotalCare Dental
Work Address	City, State	<input checked="" type="checkbox"/> Horizon Dental PPO	<input type="checkbox"/> P/C - Parent & Child
Date of Employment	Hours Worked	<input type="checkbox"/> Horizon Dental PPO Access	

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach proof if full-time college student. Attach proof of disability.									
Child (Change if Remove)	Last Name, First Name, M.I.	Sex	Birthdate	Social Security Number	Other Dental Coverage	Dentist Office ID Number (if applicable)	NPI Number	Current Patient Coverage	Previous Coverage
Employee		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Domestic Partner		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Civil Union Partner		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child		<input type="checkbox"/> M <input type="checkbox"/> F	MM DD YYYY		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

E. Other/Previous Insurance		F. Dependent Information	
Is your Spouse/Domestic Partner/Civil Union Partner Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," give name & address of spouse's/ Domestic Partners/Civil Union Partner's employer.		Does any dependent listed in Section D live at a different address than the Employee? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," who and at what address?	
If "Yes" to Other Dental Coverage (Section D), give name & policy number of insurance carrier, HMO, or other source.		Explain the circumstances.	
If "Yes" to previous coverage, identify name(s) of persons, give effective date and date coverage terminated, name of previous carrier and plan number and submit a copy of the Certificate of Credible Coverage issued by the previous carrier, if available.		If any dependent's last name differs from yours, explain the circumstances.	

G. Employee Signature		H. Employer Verification - To Be Completed by Employer	
I represent that all the information supplied in this enrollment/change request form is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of this enrollment/change request. I authorize deductions from my earnings for any required contribution.		Employer Signature - Required	
		X	
		Title: <u>Administrator</u>	
		Date: <u>1/1/2008</u>	

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Horizon BCBSNJ Dental Programs prior to visiting a specialist or admission to a hospital. Services and products may be provided by Horizon Blue Cross Blue Shield of New Jersey or Horizon Healthcare Dental, Inc., each of which is an independent licensee of the Blue Cross and Blue Shield Association. Horizon Healthcare Dental, Inc., is a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

2149 (W0208) You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to name the file and save the form with your information to your computer.

NJ-HINT



State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — HEALTH BENEFITS SECTION

P.O. Box 295, Trenton, NJ 08625-0295

State Health Benefits Program (SHBP) • School Employees' Health Benefits Program (SEHBP)

REQUIRED DOCUMENTATION FOR DEPENDENT ELIGIBILITY AND ENROLLMENT

The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the Programs. The New Jersey Division of Pensions & Benefits (NJDPB) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or overage children continuing coverage) must submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Any dependents not listed on the application will not be covered.

DEPENDENTS	ELIGIBILITY DEFINITION	DOCUMENTATION REQUIRED
SPOUSE	A person to whom you are legally married.	A copy of the marriage certificate and a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required.
CIVIL UNION PARTNER	A person of the same sex with whom you have entered into a civil union.	A copy of the marriage certificate and a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the partner. If filing separately, submit a copy of both partners' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required.
DOMESTIC PARTNER	A person of the same sex with whom you have entered into a domestic partnership. Under P.L. 2003, c. 246, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP - or SEHBP - participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.	A copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007, or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners and a copy of the front page of both partners' N.J. tax return* from last year that includes the partner.
CHILDREN	A subscriber's natural, adopted, or step child, until age 26, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation.	Natural or Adopted Child – A copy of the child's birth certificate showing the name of the employee/retiree as a parent. Step Child – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner. Legal Ward, Grandchild, or Foster Child – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee.
DEPENDENT CHILDREN WITH DISABILITIES	If a covered child is not capable of self-support when he or she reaches age 26 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuance of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP; (2) the child continues to be disabled; (3) the child is unmarried or does not enter into a civil union or domestic partnership; and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage.	Documentation for the appropriate child type (as noted above) and a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process.
CONTINUED COVERAGE FOR OVERAGE CHILDREN	Certain children over age 26 may be eligible for continued coverage until age 31 under the provisions of P.L. 2005, c. 375. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare.	Documentation for the appropriate child type (as noted above), and a copy of the front page of the child's federal tax return* (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted.

*You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. To obtain copies of the documents listed above, contact the office of the town clerk in the city of the birth, marriage, etc., or visit these websites: www.vitalrec.com or www.studentclearinghouse.org. Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: www.nj.gov/health/vital/index.shtml

INSTRUCTIONS

This form is to be completed for any member who leaves one New Jersey public employer to take a job with another New Jersey public employer but remains in the same retirement system. It is also used to establish multiple enrollment in the retirement system. A member establishes multiple enrollment when he or she is employed by more than one public agency at the same time in a position that is eligible for membership in the same retirement system.

If the new employment is covered by a different retirement system, an *Application for Interfund Transfer* should be completed instead of this form.

The *Report of Transfer/Multiple Enrollment Form* should be filed with the New Jersey Division of Pensions & Benefits (NJDPB) within 10 working days of the date employment begins. The employer should establish that the employee's membership in the retirement system has not expired or been withdrawn. If the employee's membership has expired or been withdrawn, the employee must complete a new *Enrollment Application*.

The NJDPB will process the *Report of Transfer/Multiple Enrollment Form* and will send a *Certification of Payroll Deductions* to the new employer advising the employer of the date pension deductions must begin for the transferring employee.

If any items on this form are incomplete or left blank, it will delay the processing the member's transfer or multiple enrollment. This may result in additional back pension contributions and create a hardship for the member. Therefore, the certifying officer should ensure that all items are complete prior to submission of this form.

Return completed form to:

**New Jersey Division of Pensions & Benefits
Enrollment Section
P.O. Box 295
Trenton, NJ 08625-0295**



State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS — ENROLLMENT SECTION

P.O. Box 295, Trenton, NJ 08625-0295

REPORT OF TRANSFER / MULTIPLE ENROLLMENT FORM☐ REPORT OF TRANSFER or ☐ MULTIPLE ENROLLMENT (PERS and TPAF Only)**PART 1 — MEMBER INFORMATION**1. Retirement System ☐ PERS ☐ TPAF ☐ PFRS

2. Membership Number _____

3. Social Security Number _____

4. Name _____
Last First Middle Maiden5. Address _____
Street City State Zip Code

6. Phone Number _____

PART 2 — EMPLOYER INFORMATION

7. Name of Former Employer _____

8. Date of Last Pension Deduction Reported by Former Employer _____
Month/Year or Pay Period/Year

9. Termination Date ____/____/____

10. Name of New Employer _____

11. New Employer Location/Payroll Number _____ 12. Is New Employer a Board of Education? ☐ Yes ☐ No

13. Title of New Position _____ 14. Date Current Employment Began ____/____/____

To be completed for TPAF applications only

15. Date Employment Began ____/____/____ (Do not include temporary or substitute service)

16. Does position require a New Jersey State Certificate issued by the State Board of Examiners within the N.J. Department of Education? ☐ Yes ☐ No17. Does the applicant hold a certification issued by the State Board of Examiners within the N.J. Department of Education? ☐ Yes ☐ No18. For N.J. Department of Education Only: Is the position Unclassified Professional? ☐ Yes ☐ No19. Is the applicant a Workers' Compensation Judge? ☐ Yes ☐ No20. Is the applicant appointed under the authority of a local ordinance to a statutory-based, untenured chief administrative position such as business administrator, county or municipal administrator, county or municipal manager? ☐ Yes ☐ No21. Is the applicant filling a position with principal operating responsibility of a government function(s), commonly called "department heads" or similar title, that are filled by action of the governing body and who directly report to an elected official(s) or chief administrative officer? ☐ Yes ☐ No22. Is the applicant working under a professional services contract? ☐ Yes ☐ No23. Is the applicant a bona fide employee serving in a professional services position such as an attorney, engineer, planner, doctor, or accountant at a local government entity? ☐ Yes ☐ No24. Current Annual Base Salary \$ _____ 25. Employee is paid on: ☐ 10-month basis ☐ 12-month basis26. Are the work hours fixed at 32 hours (Local) or 35 hours (State) or more per week? ☐ Yes ☐ No27. Is employee currently employed by more than one public agency? ☐ Yes ☐ No

I certify that this employee and position meets the eligibility criteria for the retirement system as provided by law. I further certify that I have successfully completed the online training and Annual Membership Certification required by N.J.S.A. 43:3C-15. I acknowledge that I am subject to penalty for falsifying or permitting to be falsified any record, application, form, or report of the retirement system in an attempt to defraud the system pursuant to N.J.S.A. 43:3C-15. Two signatures required.

Print Certifying Officer's Name_____
Signature_____
Date_____
Print Certifying Officer's Supervisor's Name_____
Signature_____
Date_____
Phone Number



PLANCONNECT CONTACT INFORMATION

GENERAL SERVICE	Toll-free, Monday through Friday, 9AM-5PM ET (800) 923-6669
BY FAX	 (800) 657-2826
BY EMAIL	 support@planconnect.com
ON THE INTERNET	Homepage and Account Login: www.planconnect.com
REGULAR MAIL	PlanConnect P.O. Box 4940 Syracuse, NY 13221
EXPRESS MAIL	PlanConnect 100 Madison Street Syracuse, NY 13202



Welcome! We're PlanConnect - Your Employer's 403(b) and 457(b) Plan Administrator

Your plan sponsor, Bayshore Jointure Commission, selected PlanConnect® as the third-party administrator for its 403(b) and 457(b) Plans. We are excited to be working with Bayshore Jointure Commission and are committed to providing you with information, tools, and resources you can use to help get the most out of the plan.

Your Employer's 403(b) and 457(b) Plans are a Valuable Benefit

Whether you are just starting out or have been working many years, the 403(b) and 457(b) Plans can be an excellent way to help you build up your retirement savings. It offers the convenience of automatic payroll deductions and gives you the ability to save with pre-tax dollars—that means your contributions and any investment earnings can be tax-deferred until withdrawn. Here's some important information about the plan.

Who Is Eligible

You are generally eligible to participate in your employer's 403(b) Plan if you are a full-time or part-time employee.

However, IRS rules permit 403(b) Plans to exclude employees if any of the following apply. To learn about your employer's 403(b) eligibility requirements, visit www.planconnect.com to log in to the plan website and select "References > Plan Information > Your Plan Features" on the main menu or contact PlanConnect using the contact information provided in the last section of this notice.

- Employee will contribute \$200 annually or less.
- Employee is a non-resident alien who receives no compensation which constitutes U.S. source income.
- Employee normally work less than 20 hours per week and are either not expected to work 1,000 hours or more during the first year of employment, or has worked less than 1,000 hours in the prior calendar year.
- Employee is eligible to participate in another 403(b), 401(k), or governmental 457(b) plan of the employer.
- Employee is a student performing services for a school, college, or university described in Section 3121(b)(10) of the Internal Revenue Code.
- Employee is leased or an independent contractor.

To learn more about the 457(b) eligibility requirements please go to www.planconnect.com to log in to the plan website and select "References > Plan Information > Your Plan Features" on the main menu.

How to Enroll

Current plan participants

You do not need to re-enroll in the plan or take any other action.

New plan participants

You can enroll at any time. It's easy:

- First complete an annuity contract or custodial account application to set up your plan account. Application forms are available from the representative of the investment provider you select. For a list of available investment providers log on to www.planconnect.com and select "Investments > Investment Provider".
- Then, complete a salary reduction agreement form by either going on-line or by contacting PlanConnect at the phone number indicated in the last section of this notice.
- Your participation will begin at the start of the payroll period following the date PlanConnect® and your Payroll Department process your completed salary reduction agreement.

Contributions to the Plan

What type of contributions can I make to the plan?

Your employer's plan accepts pre-tax salary deferral contributions and may permit other types of contributions. To learn more, please log into the plan website and select "References > Plan Information > Your Plan Features" or contact PlanConnect.

Change or stop your contributions at any time

Just log in to www.planconnect.com and select "Log Into Your Account". Or, you can contact PlanConnect at the phone number indicated in the last section of this notice. The change will take effect at the start of the payroll period following the date your Payroll Department processes your request.

The first time you log on to www.planconnect.com

Your user ID is your Social Security Number (without any spaces or dashes) and your password is your date of birth (mmddyyyy). You can change your user ID and password any time after your initial login.



403(b) SALARY REDUCTION AND INVESTMENT ELECTION AGREEMENT

Employer/Plan Name: _____ PlanConnect Plan ID: _____

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____-____-____ Social Security Number: ____-____-____

Home Phone Number: ____-____-____ Work Phone Number: ____-____-____

E-Mail Address: _____

If you have or will be making elective contributions to another employer's plan this year, please indicate the amount: \$ _____

Read the Participant Obligation section before completing.

BEGIN / RESUME / CHANGE	I authorize my employer to reduce my salary to allow for contributions to be made to a 403(b) account on my behalf and to remit the designated amounts each pay period to the investment provider(s) indicated below. I have confirmed the investment provider(s) are approved by my employer's plan. I have read and will abide by the Participant Obligations section. I understand that this Salary Reduction Agreement is legally binding and irrevocable with respect to salary that becomes payable to me while this agreement is in effect. I understand that I may stop, start, or change my future contribution amount at any time during the year by submitting a new Salary Reduction Agreement.				
	IMPORTANT: You must have an existing 403(b) account with each investment provider listed, or file an account application with the investment provider, BEFORE your first contribution is taken. Please allow two to four weeks for your investment provider to properly credit contributions to new accounts.				
	Participant Contributions. If more than 2 Investment Providers, attach separate sheet.				
	This Salary Reduction Agreement REPLACES AND CANCELS ALL PREVIOUS AGREEMENTS ON FILE, UNLESS THE ONE-TIME ELECTION IS SELECTED. ONLY the contribution to the investment provider(s) shown below will continue after the effective date of this agreement, UNLESS THE ONE-TIME ELECTION IS SELECTED. Complete all sections and forward to PlanConnect using the instructions under the contact section of this form. Prior elections on file will resume for ONE-TIME ELECTIONS ONLY. Current provider and source will be utilized on forms where "CHANGE" is selected and investment provider and source are omitted.				
BEGIN / RESUME / CHANGE	Effective Date of Agreement:		<input type="checkbox"/> Next Permissible Date	<input type="checkbox"/> Other: _____	
			<input type="checkbox"/> One-Time Election Payout Date: _____		
	If the effective date specified does not align with a permissible plan entry date or pay cycle, the election will be effective as soon as administratively possible thereafter.				
BEGIN / RESUME / CHANGE	Remit Contributions To:		I have an Account with this provider.	Amount Percent or Dollar must be an acceptable method for the employer	Contribution Source Check one: Source must be permitted by the plan
	Amounts are on a per pay basis.				
	<input type="checkbox"/> Begin/Continue <input type="checkbox"/> Change <input type="checkbox"/> Stop <input type="checkbox"/> One Time	Investment Provider/Account Number	<input type="checkbox"/> Yes <input type="checkbox"/> No	OR % \$	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Roth
	<input type="checkbox"/> Begin/Continue <input type="checkbox"/> Change <input type="checkbox"/> Stop <input type="checkbox"/> One Time	Investment Provider/Account Number	<input type="checkbox"/> Yes <input type="checkbox"/> No	OR % \$	<input type="checkbox"/> Pre-Tax <input type="checkbox"/> Roth
BEGIN / RESUME / CHANGE	EMPLOYER CONTRIBUTIONS (if applicable), will be allocated proportionately in accordance with the investment provider elections you have specified above, unless specified differently by the employer.				
CONTACT	EXPRESS MAIL: PlanConnect 100 Madison Street Syracuse, NY 13202	REGULAR MAIL: PlanConnect PO Box 4940 Syracuse, NY 13221	FAX: (800) 657-2826	PHONE: (800) 923-6669 Monday-Friday, 9AM to 5PM ET www.planconnect.com	
SIGN	Incomplete forms will result in a processing delay or may not be accepted.				
	Employee Signature: _____		Date: _____		
	Advisor Signature: _____		Date: _____		
KEEP A COPY FOR YOUR RECORDS (Check your earnings statement to verify this Salary Reduction Agreement was processed accurately.)					

The following applies to all participants in the 457(b) Deferred Compensation Program:

1. Federal Contribution Limits: Contributions are subject to annual limits determined under Internal Revenue Code (IRC) sec. 402(g) and 415(c). To learn more about this year's Federal Contribution Limits, go to <http://www.planconnect.com/limits>. These limits may be indexed annually based on the Consumer Price Index. The IRS publishes the limits in the last quarter of the year for the following year.

If you are within 3 years of retirement age as defined by your plan, you may be eligible to contribute an additional amount. Contact PlanConnect to determine if you are eligible. Contributions to a 403(b) plan, traditional or Roth IRA accounts do not affect your 457(b) limits. To learn more about the different types of contributions go to <https://www.irs.gov/Retirement-Plans/Plan-Participant-Employee/Retirement-Topics-Contributions>.

2. Investment Responsibility: You are responsible for your investment decisions. This responsibility includes informing yourself of the nature and risk of the investments, monitoring your investments, and determining when a change in investments is appropriate. Your employer and PlanConnect are in no way liable for gains or losses you may incur in your account(s).

3. Authorized Investment Providers: As long as your current employer employs you, you may make contributions only to investment providers and products authorized under this 457(b) program. You may change your future contributions to a different authorized investment provider, or exchange all or a portion of your account balance to any other approved investment provider, if permitted by your plan and subject to approval and any contractual surrender charges or redemption fees.

4. Withdrawals and Loans: Generally, you cannot withdraw or roll over your account balances before you attain age 59 ½ for governmental or 70 ½ for non-governmental, your account value is \$5,000 or less and no contributions have been made to the account for at least two years prior to the withdrawal or you terminate employment, subject to the terms of your employer's plan. Your account balances may be assigned to your alternate payee as ordered by a court under a Qualified Domestic Relations Order (QDRO). Loans and unforeseen financial emergency withdrawals, as limited by IRS regulations, are subject to approval if permitted by your 457(b) Plan provisions. Other withdrawals, if permitted under the plan, may also be subject to approval. You are entirely responsible for all loans and withdrawals and any resulting tax liabilities.

5. Deferred Compensation Agreement (DCA) Termination: To stop your contributions, you must file a new copy of the DCA with your employer and PlanConnect. If you terminate employment, your DCA terminates automatically after your last check is paid. If you later return to work, you must file a new DCA to resume contributing. **Your employer reserves the right to suspend or terminate a participant's DCA if it believes that the participant has over contributed, terminated the account with the elected investment provider, or is in violation of any applicable federal requirement or any term of this agreement.**

6. Required Distributions: After you retire, you must take minimum distributions from your account(s), generally beginning no later than age 70 ½ or 72 for those who turned 70 of July 1, 2019 or later. You do not need to take Required Minimum Distributions from your account(s) as long as you are still working for your current employer and the plan permits it, even though you may be over age 70 ½ or 72, as applicable.

7. Effective Date: The Code requires that the employer receive this agreement before the first day of the month in which contributions will begin or change. If necessary to meet that requirement, the Employer reserves the right to change the effective date of contributions.

8. Corrections: It is your responsibility to verify that this agreement has been accurately processed by comparing it to your earnings statement. Contact your Payroll Administration Department immediately if you find any discrepancy. In volatile markets, the value of your contribution may decline over time.

9. Fees: PlanConnect provides services to the Plan for a fee. The Plan Sponsor may elect to collect the fees from the Investment Providers or Plan Participants.

10. Employer Contributions: You understand that you do not have the option to take employer contributions as cash or in any other form of payment and that you can only select investment providers for such contributions.

Bayshore Jointure Commission 457(b) Plan Financial Advisors

Investment Providers	Financial Advisor	Phone
Equitable	Todd Speedy	(732) 606-8445 Todd.Speedy@equitable.com
	Joseph Giles	(732) 606-8400 Joseph.Giles@equitable.com