FORMS

FORMS INDEX

AFFIDAVIT – LIST OF CHURCH'S BANK AND INVESTMENT ACCOUNTS

We, the Pastor and the Church Treasurer, hereby affirm that this report lists all the bank and investment accounts that held funds of the _____ Seventh-day Adventist Church during the audit period from _____, 20 _____ through _____, 20_____.

Name of Bank or Institution	**Account Name**	**Account Number**

_____ _____
Pastor Church Treasurer

_____ _____
Date Date

ϖ ϖ ϖ

Note: Attach invoice, disbursement voucher, or other evidence of authorization for payment to the upper portion of this form and fill in information called for on the blank lines below.

If no invoice is available (which will be the case for such items as rent and loan payments) fill in the requested information below and place this form in the disbursement voucher file in regular numerical order according to check number.

DO NOT ATTACH THE CANCELED CHECK TO THIS SHEET.

DATE _____ AMOUNT $ _____

PAID TO _____

FOR _____

CHARGE TO _____ CHECK NO. _____

CHECK REQUEST

Requested by: _____

(Print Name)

Date: _____

Pay to: _____

(Print Name)

Amount: $_____

Purpose: _____

Charge to: _____

Approved: _____

CHECK REQUEST

Requested by: _____

(Print Name)

Date: _____

Pay to: _____

(Print Name)

Amount: $_____

Purpose: _____

Charge to: _____

Approved: _____

CHECK REQUEST

Requested by: _____

(Print Name)

Date: _____

Pay to: _____

(Print Name)

Amount: $_____

Purpose: _____

Charge to: _____

Approved: _____

DATE:_____AMOUNT:_____

PAID TO:_____

FOR_____

CHARGE TO_____ CHECK NO._____

SUPPLY ORDER FORM

NAME OF CHURCH _____

Please send the following order of supplies to:

Name _____

Address _____

City_____ Zip _____

NUMBER	DESCRIPTION
	Tithe Envelope — ***English***
	Tithe Envelope **— Spanish**
	Envelope Front Pad — ***English***
	Envelope Front Pad — **Spanish**
	Weekly Mailing Envelopes — Small (4 ½ x 10 ½)
	Weekly Mailing Envelopes — Large (7 x 10)

Date Received_____ Date Sent _____

How to Apply for an EIN

Español

Applying for an EIN is a free service offered by the Internal Revenue Service. Beware of websites on the Internet that charge for this free service.

If you are a home-care service recipient who has a previously assigned EIN either as a sole proprietor or as a household employer, do not apply for a new EIN. Use the EIN previously provided. If you can not locate your EIN for any reason, follow the instructions on the Lost or Misplaced Your EIN? Web page.

Apply Online

The Internet EIN application is the preferred method for customers to apply for and obtain an EIN. Once the application is completed, the information is validated during the online session, and an EIN is issued immediately. The online application process is available for all entities whose principal business, office or agency, or legal residence (in the case of an individual), is located in the United States or U.S. Territories. The principal officer, general partner, grantor, owner, trustor etc. must have a valid Taxpayer Identification Number (Social Security Number, Employer Identification Number, or Individual Taxpayer Identification Number) in order to use the online application.

Apply by Fax

Taxpayers can fax the completed Form SS-4 (PDF) application to their state fax number (see Where to File Your Taxes (for Form SS-4)), after ensuring that the Form SS-4 contains all of the required information. If it is determined that the entity needs a new EIN, one will be assigned using the appropriate procedures for the entity type. If the taxpayer's fax number is provided, a fax will be sent back with the EIN within four (4) business days.

Apply by Mail

The processing timeframe for an EIN application received by mail is four weeks. Ensure that the Form SS-4 (PDF) contains all of the required information. If it is determined that the entity needs a new EIN, one will be assigned using the appropriate procedures for the entity type and mailed to the taxpayer. Find out where to mail Form SS-4 on the Where to File Your Taxes (for Form SS-4) page.

Apply by Telephone – International Applicants

International applicants may call 267-941-1099 (not a toll-free number) 6:00 a.m. to 11:00 p.m. (Eastern Time) Monday through Friday to obtain their EIN. The person making the call must be authorized to receive the EIN and answer questions concerning the Form SS-4 (PDF), *Application for Employer Identification Number*. Complete the Third Party Designee section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of Form SS-4. The designee's authority terminates at the time the EIN is assigned and released to the designee. You must complete the signature area for the authorization to be valid.

Other Important Information

Daily Limitation of an Employer Identification Number

Effective May 21, 2012, to ensure fair and equitable treatment for all taxpayers, the Internal Revenue Service will limit Employer Identification Number (EIN) issuance to one per responsible party per day. This limitation is applicable to all requests for EINs whether online or by fax or mail. We apologize for any inconvenience this may cause.

Responsible Party

In order to identify the correct individuals and entities applying for EINs, language changes have been made to the EIN process. Refer to Responsible Parties and Nominees to learn about these important changes before applying for an EIN.

Third Party Authorization

The Third Party Designee section must be completed at the bottom of the Form SS-4. The Form SS-4 must also be signed by the taxpayer for the third party designee authorization to be valid. The Form SS-4 must be mailed or faxed to the appropriate service center. The third party designee's authority terminates at the time the EIN is assigned and released to the designee.

Form **SS-4**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

► **See separate instructions for each line.** ► **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested

2 Trade name of business (if different from name on line 1) | **3** Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box) | **5a** Street address (if different) (Do not enter a P.O. box.)

4b City, state, and ZIP code (if foreign, see instructions) | **5b** City, state, and ZIP code (if foreign, see instructions)

6 County and state where principal business is located

7a Name of responsible party | **7b** SSN, ITIN, or EIN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? . . . . . ☐ **Yes** ☐ **No**

8b If 8a is "Yes," enter the number of LLC members . . . . ►

8c If 8a is "Yes," was the LLC organized in the United States? . . . . . ☐ **Yes** ☐ **No**

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN) ___ ___ ___
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ►
- ☐ Personal service corporation
- ☐ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ►
- ☐ Other (specify) ►
- ☐ Estate (SSN of decedent) ___ ___ ___
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ►

9b If a corporation, name the state or foreign country (if applicable) where incorporated | State | Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ►
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ►
- ☐ Banking purpose (specify purpose) ►
- ☐ Changed type of organization (specify new type) ►
- ☐ Purchased going business
- ☐ Created a trust (specify type) ►
- ☐ Created a pension plan (specify type) ►

11 Date business started or acquired (month, day, year). See instructions.

12 Closing month of accounting year

13 Highest number of employees expected in the next 12 months (enter -0- if none).

If no employees expected, skip line 14.

Agricultural	Household	Other

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) . . . . . ►

16 Check **one** box that best describes the principal activity of your business.

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail ☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☐ Other (specify)

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ **Yes** ☐ **No**

If "Yes," write previous EIN here ►

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name | Designee's telephone number (include area code) ( )

Address and ZIP code | Designee's fax number (include area code) ( )

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

Name and title (type or print clearly) ► | Applicant's telephone number (include area code) ( )

Signature ► Date ► | Applicant's fax number (include area code) ( )

Do I Need an EIN?

File Form SS-4 if the applicant entity does not already have an EIN but is required to show an EIN on any return, statement, or other document.[1] See also the separate instructions for each line on Form SS-4.

IF the applicant...	AND...	THEN...
Started a new business	Does not currently have (nor expect to have) employees	Complete lines 1, 2, 4a–8a, 8b–c (if applicable), 9a, 9b (if applicable), and 10–14 and 16–18.
Hired (or will hire) employees, including household employees	Does not already have an EIN	Complete lines 1, 2, 4a–6, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10–18.
Opened a bank account	Needs an EIN for banking purposes only	Complete lines 1–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Changed type of organization	Either the legal character of the organization or its ownership changed (for example, you incorporate a sole proprietorship or form a partnership) [2]	Complete lines 1–18 (as applicable).
Purchased a going business [3]	Does not already have an EIN	Complete lines 1–18 (as applicable).
Created a trust	The trust is other than a grantor trust or an IRA trust [4]	Complete lines 1–18 (as applicable).
Created a pension plan as a plan administrator [5]	Needs an EIN for reporting purposes	Complete lines 1, 3, 4a–5b, 9a, 10, and 18.
Is a foreign person needing an EIN to comply with IRS withholding regulations	Needs an EIN to complete a Form W-8 (other than Form W-8ECI), avoid withholding on portfolio assets, or claim tax treaty benefits [6]	Complete lines 1–5b, 7a–b (SSN or ITIN optional), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is administering an estate	Needs an EIN to report estate income on Form 1041	Complete lines 1–6, 9a, 10–12, 13–17 (if applicable), and 18.
Is a withholding agent for taxes on non-wage income paid to an alien (i.e., individual, corporation, or partnership, etc.)	Is an agent, broker, fiduciary, manager, tenant, or spouse who is required to file Form 1042, Annual Withholding Tax Return for U.S. Source Income of Foreign Persons	Complete lines 1, 2, 3 (if applicable), 4a–5b, 7a–b (if applicable), 8a, 8b–c (if applicable), 9a, 9b (if applicable), 10, and 18.
Is a state or local agency	Serves as a tax reporting agent for public assistance recipients under Rev. Proc. 80-4, 1980-1 C.B. 581 [7]	Complete lines 1, 2, 4a–5b, 9a, 10, and 18.
Is a single-member LLC	Needs an EIN to file Form 8832, Classification Election, for filing employment tax returns and excise tax returns, or for state reporting purposes [8]	Complete lines 1–18 (as applicable).
Is an S corporation	Needs an EIN to file Form 2553, Election by a Small Business Corporation [9]	Complete lines 1–18 (as applicable).

[1] For example, a sole proprietorship or self-employed farmer who establishes a qualified retirement plan, or is required to file excise, employment, alcohol, tobacco, or firearms returns, must have an EIN. A partnership, corporation, REMIC (real estate mortgage investment conduit), nonprofit organization (church, club, etc.), or farmers' cooperative must use an EIN for any tax-related purpose even if the entity does not have employees.

[2] However, do not apply for a new EIN if the existing entity only (a) changed its business name, (b) elected on Form 8832 to change the way it is taxed (or is covered by the default rules), or (c) terminated its partnership status because at least 50% of the total interests in partnership capital and profits were sold or exchanged within a 12-month period. The EIN of the terminated partnership should continue to be used. See Regulations section 301.6109-1(d)(2)(iii).

[3] Do not use the EIN of the prior business unless you became the "owner" of a corporation by acquiring its stock.

[4] However, grantor trusts that do not file using Optional Method 1 and IRA trusts that are required to file Form 990-T, Exempt Organization Business Income Tax Return, must have an EIN. For more information on grantor trusts, see the Instructions for Form 1041.

[5] A plan administrator is the person or group of persons specified as the administrator by the instrument under which the plan is operated.

[6] Entities applying to be a Qualified Intermediary (QI) need a QI-EIN even if they already have an EIN. See Rev. Proc. 2000-12.

[7] See also *Household employer* on page 4 of the instructions. **Note.** State or local agencies may need an EIN for other reasons, for example, hired employees.

[8] See *Disregarded entities* on page 4 of the instructions for details on completing Form SS-4 for an LLC.

[9] An existing corporation that is electing or revoking S corporation status should use its previously-assigned EIN.

Form **SS-4**
(Rev. January 2010)
Department of the Treasury
Internal Revenue Service

Application for Employer Identification Number

(For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.)

▶ **See separate instructions for each line.** ▶ **Keep a copy for your records.**

OMB No. 1545-0003

EIN

Type or print clearly.

1 Legal name of entity (or individual) for whom the EIN is being requested
ABC SEVENTH-DAY ADVENTIST CHURCH

2 Trade name of business (if different from name on line 1)

3 Executor, administrator, trustee, "care of" name

4a Mailing address (room, apt., suite no. and street, or P.O. box)
12345 STREET

5a Street address (if different) (Do not enter a P.O. box.)
12345 STREET

4b City, state, and ZIP code (if foreign, see instructions)
RIVERSIDE, CA 91234

5b City, state, and ZIP code (if foreign, see instructions)
RIVERSIDE, CA 91234

6 County and state where principal business is located
RIVERSIDE COUNTY, CA

7a Name of responsible party
TREASURER'S NAME

7b SSN, ITIN, or EIN
TREAS SSN

8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? ☐ Yes ☑ No

8b If 8a is "Yes," enter the number of LLC members ▶

8c If 8a is "Yes," was the LLC organized in the United States? ☐ Yes ☐ No

9a **Type of entity** (check only one box). **Caution.** If 8a is "Yes," see the instructions for the correct box to check.

- ☐ Sole proprietor (SSN)
- ☐ Partnership
- ☐ Corporation (enter form number to be filed) ▶
- ☐ Personal service corporation
- ☑ Church or church-controlled organization
- ☐ Other nonprofit organization (specify) ▶
- ☐ Other (specify) ▶
- ☐ Estate (SSN of decedent)
- ☐ Plan administrator (TIN)
- ☐ Trust (TIN of grantor)
- ☐ National Guard ☐ State/local government
- ☐ Farmers' cooperative ☐ Federal government/military
- ☐ REMIC ☐ Indian tribal governments/enterprises

Group Exemption Number (GEN) if any ▶

9b If a corporation, name the state or foreign country (if applicable) where incorporated — State — Foreign country

10 **Reason for applying** (check only one box)

- ☐ Started new business (specify type) ▶
- ☐ Hired employees (Check the box and see line 13.)
- ☐ Compliance with IRS withholding regulations
- ☐ Other (specify) ▶
- ☑ Banking purpose (specify purpose) ▶ OPEN A BANK ACCOUNT
- ☐ Changed type of organization (specify new type) ▶
- ☐ Purchased going business
- ☐ Created a trust (specify type) ▶
- ☐ Created a pension plan (specify type) ▶

11 Date business started or acquired (month, day, year). See instructions.
BEST GUESS, CHECK WITH SECRETARY OF CONF.

12 Closing month of accounting year DECEMBER USUALLY

13 Highest number of employees expected in the next 12 months (enter -0- if none). If no employees expected, skip line 14.

Agricultural	Household	Other
0	0	0

14 If you expect your employment tax liability to be $1,000 or less in a full calendar year **and** want to file Form 944 annually instead of Forms 941 quarterly, check here. (Your employment tax liability generally will be $1,000 or less if you expect to pay $4,000 or less in total wages.) If you do not check this box, you must file Form 941 for every quarter. ☐

15 First date wages or annuities were paid (month, day, year). **Note.** If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year) ▶

16 Check **one** box that best describes the principal activity of your business.

☐ Construction ☐ Rental & leasing ☐ Transportation & warehousing ☐ Health care & social assistance ☐ Accommodation & food service ☐ Wholesale-agent/broker ☐ Wholesale-other ☐ Retail
☐ Real estate ☐ Manufacturing ☐ Finance & insurance ☑ Other (specify) ▶ RELIGIOUS ACTIVITIES

17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided.
RELIGIOUS SERVICES PROVIDED

18 Has the applicant entity shown on line 1 ever applied for and received an EIN? ☐ Yes ☑ No
If "Yes," write previous EIN here ▶

Third Party Designee

Complete this section **only** if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.

Designee's name — Designee's telephone number (include area code)

Address and ZIP code — Designee's fax number (include area code)

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

Name and title (type or print clearly) ▶ TREASURER — Applicant's telephone number (include area code) TREASURER

Signature ▶ — Date ▶ — Applicant's fax number (include area code) TREASURER

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 16055N Form **SS-4** (Rev. 1-2010)

Form **W-9**
(Rev. November 2017)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Southeastern California Conference
New Employee Checklist

Employee Name: _____ Date: _____

Place of Employment: _____

Please follow the directions stated for each document and submit these documents, with this checklist to ***the Human Resources Department***. Keep a copy of all forms for your records until the employee is processed through payroll. ***All documents must be completed prior to the employee's first day of work***.

□ **PERSONNEL ACTION REQUEST**
Who: To be completed by church pastor or authorized representative.
Where: Original to Human Resources (all copies)
Processing: Completed and signed by pastor or church administrator. Must include name of employee, status, rate, hours of work per week, starting date, church name, and signature of church official.

□ **APPLICATION FOR EMPLOYMENT**
Who: All employees
Where: Original to Human Resources. Keep a copy on site.
Processing: Completed by employee, and signed at the bottom of the second page.

□ **W-4 FORM**
Who: All employees
Where: Human Resources
Processing: Be sure items 1, 2, 3, and 4 are complete. Then, either item 5 **OR** 7 should be completed but **NOT BOTH**. This document must also be signed and dated by the employee. You may request to see an employee's Social Security Card, and if they provide the card, you may make a copy for payroll purposes to be submitted with the W-4.

□ **EMPLOYMENT ELIGIBILITY (I-9 FORM)**
Who: All employees
Where: Original to Human Resources. Keep a copy on site.
Processing: Employee completes and signs Section 1. Section 2 is completed by an employee of the church that witnesses the employee's actual identification, chosen from the back of the I-9 form (one item from list A, or one item from list B **AND** one from list C), and signs the certification. **Please note that this must be done on site as the actual identification must be witnessed and certified.**

□ **COPY OF DOCUMENTS USED FOR THE I-9**
Who: All employees
Where: Copy of documents to Human Resources.
Processing: A copy of the documents used to complete section 2 of the I-9 form is **REQUIRED**.

□ **CONFLICT OF INTEREST FORM**
Who: All employees
Where: Original to Human Resources
Processing: Completed and signed by the employee.

□ **SERVICE RECORD FORM**
Who: All employees
Where: Original to Human Resources.
Processing: Completed by employees. **Please list last denominational service only under the Employment section.**

□ **NEW EMPLOYEE DATA COLLECTION**
Who: All employees
Where: Original to Human Resources. Keep a copy on site.
Processing: Completed and **signed** by the employee.

□ **BACKGROUND CHECK AUTHORIZATION**
Who: All employees
Where: Original to Human Resources.
Processing: Completed and signed by the employee.

□ **Church Membership Check Form**
Who: All employees
Where: Original to Human Resources.
Processing: Completed and signed by the employee.

If you have any questions or need information or assistance in completing any of these forms, please contact the Human Resources Department at 951.509.2353

PERSONNEL ACTION REQUEST

Southeastern California Conference of Seventh-day Adventists

(office use)

Emp.#: _____

Base Accrual Date:

EMPLOYEE INFO

Employee Name: _____

☐ New position (include job description) **Supervisory position: YES** ☐ **NO** ☐

NEW ☐

REHIRE ☐

ADDITIONAL ASSIGNMENT ☐

☐ Full-Time ☐ Regular ☐ On-Call ☐ Biweekly Salary: _____

☐ Part-Time ☐ Temporary (3 Month Maximum) ☐ Hourly Rate: _____

Job Title: _____ Name of Supervisor: _____

Place of Work: _____ Date Voted by Local Board: _____

Hours/Week or FTE: _____ Starting Date: _____ Ending Date: _____

☐ Part-time/on-call employee expected to work 30 days or more this year

In addition to the wages, there are other employment expenses. HR assumes no responsibility for budget calculations.

Comments: _____

CHANGE ☐

LTD ☐

Current Work Location: _____ Effective Date: _____

☐ New Work Location: _____ ☐ Hours/Week or FTE: _____

☐ Job Title: _____ ☐ Bi-Weekly Salary/Hourly Rate: _____

☐ Status Change: ☐ Full-Time ☐ Part-Time ☐ Regular ☐ Temporary ☐ On-Call ☐ LTD (DI 42022)

Comments: _____

TERMINATION ☐

SETTLEMENT ☐

Effective Date: _____ Work Location: _____

☐ Resignation (attach letter) ☐ Layoff/Reduction-In Force ☐ Dismissal ☐ Retirement

☐ Other: _____ ☐ Leave of Absence Begin: _____ End: _____

Vacation/Paid Leave Due: _____

Comments: _____

Initiating Supervisor _____ _____ Date _____
(signature) (print)

Department Head _____ _____ Date _____
(signature) (print)

TO BE COMPLETED BY HUMAN RESOURCES:

Qualifies for: ☐ LTD (DI 42022) ☐ Cell Phone _____

☐ Approved ☐ Not Approved Date: _____

☐ Medical ☐ Auto ☐ Retirement ☐ Paid Leave/Vacation ☐ Parsonage

Remuneration _____ Cost Area _____ FTE _____ Travel _____

EEOC Number _____ Worker's Comp Title/Code _____ Credential _____

Charge to _____

Comments: _____

Audited by: _____ **Date:** _____

FTE Audit by: _____ **Date:** _____

Human Resources Director (sign) **Date**

06/2015

☐ - Human Resources ☐ - Payroll ☐ - Insurance ☐ - Supervisor ☐ - Employee ☐ - Service Records

Southeastern California Conference of
Seventh-day Adventists

EMPLOYMENT APPLICATION

11330 Pierce Street
Riverside, CA 92515

Phone: (951) 509-2352 • Fax: (951) 509-2395

Equal Employment Opportunity Employer

Southeastern California Conference is a religiously-qualified Equal Opportunity Employer, with the right to prefer Seventh-day Adventists in hiring. It is the policy of Southeastern California Conference to recruit and promote for all job classifications on the basis of merit, qualification, competence, attitude and spiritual commitment. No aspect of employment shall be influenced by race, color, national origin, sex, age or handicap.

TYPE or PRINT — Complete all sections, even if a resume is submitted.

Position applied for: _____ Location: _____ Date _____

PERSONAL DATA: **New Hire** _____ **Rehire** _____ **Original hire date** _____

Name _____

Address _____ Telephone (_____) _____

City _____ State _____ Zip _____ Email Address _____

Birth date (if under 18) _____

Are you a member of the Seventh-day Adventist Church? Yes____, No____. Number of years, if member _____

Location/Name of Church _____ Pastor _____

If hired, can you provide satisfactory proof of identity and legal authority to work in the U.S. as required by the U.S. Department of Homeland Security. (I-9 Form)? Yes _____ No _____

EDUCATION: **Complete the following for each school attended. (High school and above)**

School (City & State)	Curriculum or Major	Degree or Hours Completed

Trade, Technical or Business School	Course of Study	Certificate and Year

LICENSES OR CREDENTIALS:

☐ Ministerial License ☐ Missionary Credential ☐ Other _____

OTHER SKILLS:

If applicable to position — which of the following do you have knowledge of?

☐ Adobe Suite

☐ Microsoft Office Suite

☐ Typing — wpm _____

☐ Other _____

Do you speak, read or write any languages other than English? _____

APPLICATION MUST BE SIGNED, DATED AND COMPLETED ON BOTH SIDES

EMPLOYMENT RECORD: List most recent first.

DATES FROM	TO	EMPLOYER NAME, ADDRESS, AND PHONE	INDICATE YOUR JOB AND MAJOR DUTIES:	REASON FOR LEAVING
			TITLE:	
			DUTIES:	
				IMMEDIATE SUPERV:
			TITLE:	
			DUTIES:	
				IMMEDIATE SUPERV:
			TITLE:	
			DUTIES:	
				IMMEDIATE SUPERV:

ADDITIONAL INFORMATION: List any other experience or skill that you believe contributes to your qualifications for this position:

_____

_____

_____

REFERENCES: List below three persons other than relatives who can provide both character and employment references:

Name	Title	Email Address	Phone Number

VERIFICATION OF APPLICATION INFORMATION

I hereby certify that all of the information on this employment application and any resume or exhibit is true, correct and complete. I have not withheld any information requested on this application. I understand that false, misleading, incomplete or omitted information on this application or my resume will result in disqualification for employment or, if I am hired, dismissal from employment. I hereby authorize the Southeastern California Conference of Seventh-day Adventists ("SECC") to thoroughly investigate my references, work record, education and other matters related to my suitability for employment and, further, authorize the references I have listed to disclose to the SECC any and all letters, reports and other information related to my work records, without giving me prior notice of such disclosure. I agree to furnish additional information if requested. I release all parties and persons from any claims, liabilities and damages that may result from requesting or furnishing information about me to the employing organization, as well as from using such information in considering my employment application. I am a member in good and regular standing of the Seventh-day Adventist church, and abide by its teachings. I understand that if I receive a conditional employment offer, I may be asked to take a job-related medical examination with a physician selected by the employing organization. The results of this examination will be communicated to the employing organization and considered in evaluating my application. If I refuse to take such a medical examination, I understand that I will be disqualified from employment. I understand that if employed I must complete an I-9 form and provide satisfactory proof of my identity and legal authority to work in the United States. If employed, I agree to conform to the policies and standards of the employing organization. I understand that no one other than the conference administrator or designee is authorized to enter into any employment agreement for any specific time period, or to make any agreement contrary to the foregoing.

Print Name	Signature of Applicant	Date

Form W-4 (2018)

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

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

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

• For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**

• For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

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

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

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

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

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

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

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

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

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074
2018

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

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	**5**	
6	Additional amount, if any, you want withheld from each paycheck	**6**	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ►	**7**	

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

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

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

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

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

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

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

Two-Earners/Multiple Jobs Worksheet

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

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

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

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

Instructions for Employer

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

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

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

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

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

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

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	**A**	
B	Enter "1" if you will file as married filing jointly	**B**	
C	Enter "1" if you will file as head of household	**C**	
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**D**	
E	**Child tax credit.** See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child. • If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child. • If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-"	**E**	
F	**Credit for other dependents.** • If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent. • If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents). • If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-"	**F**	
G	**Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here	**G**	
H	Add lines A through G and enter the total here ►	**H**	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These 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. See Pub. 505 for details	**1**	$
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	**2**	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	**3**	$
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	**4**	$
5	**Add** lines 3 and 4 and enter the total	**5**	$
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	**7**	$
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H above	**9**	
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earners/Multiple Jobs Worksheet

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

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

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

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

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

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

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

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

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

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

9 **Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck . . . . . **9** $

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

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

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

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

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

SOUTHEASTERN CALIFORNIA CONFERENCE OF SEVENTH-DAY ADVENTISTS
AUTHORIZATION FOR DIRECT DEPOSIT OF PAYROLL

Employee Information

Name_____ Social Security Number (Last 4 only) or PR ID_____

Email Address_____ Effective Date _____

This address will be used for distribution of pay stub.

Primary Account — *This is the account where your entire paycheck or the balance is deposited after the % or $ amount is deducted from the second and third accounts as listed below.*

Select One:	Account Type		
☐ New	☐ Checking	ABA Transit Routing Number ☐☐☐☐☐☐☐☐☐	NET PAY
☐ Change	☐ Savings	Account Number _____	
		Name of Banking Institution _____	
		Bank Office/Branch _____	

Second Account — *Optional* **— % or $ Amount**

Select One:	Account Type		
☐ New	☐ Checking	ABA Transit Routing Number ☐☐☐☐☐☐☐☐☐	Select One:
☐ Change	☐ Savings	Account Number _____	_____%
		Name of Banking Institution _____	$_____
		Bank Office/Branch _____	

Third Account — *Optional* **— % or $ Amount**

Select One:	Account Type		
☐ New	☐ Checking	ABA Transit Routing Number ☐☐☐☐☐☐☐☐☐	Select One:
☐ Change	☐ Savings	Account Number _____	_____%
		Name of Banking Institution _____	$_____
		Bank Office/Branch _____	

I hereby authorize Southeastern California Conference to direct deposit funds to my account(s) in the financial institution(s) listed above. If any of the information listed above changes, I will promptly complete a new authorization agreement. If I wish to revoke this authorization, I will do so in writing.

Employee Signature_____ Date _____

FAX 951-509-2393 • EMAIL payroll@seccsda.org

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**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):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 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. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

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

STOP *Employer Completes Next Page* STOP

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 Issuing Authority Document Number Expiration Date *(if any)(mm/dd/yyyy)*		Document Title Issuing Authority Document Number Expiration Date *(if any)(mm/dd/yyyy)*		Document Title Issuing Authority Document Number Expiration Date *(if any)(mm/dd/yyyy)*
Document Title Issuing Authority Document Number Expiration Date *(if any)(mm/dd/yyyy)*		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
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
1. U.S. Passport or U.S. Passport Card		**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		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**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		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**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. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (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.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
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		**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		

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

EMPLOYEE DATA COLLECTION FORM

_____ _____

Employee Signature **Date**

Print Legal Name: _____

Home Address: _____

_____

Mailing Address: _____

_____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Birthdate: _____ Employee Gender: □ Male □ Female

Marital Status: □ Single □ Married Date of Marriage: _____

Name of Spouse: _____ Spouse Date of Birth: _____

Names of Children:	Date of Birth:	Gender:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Employee Ethnicity:

□ American Indian/Alaskan Native	□ Black or African American	□ Asian	□ White
□ Native Hawaiian or Pacific Islander	□ Hispanic or Latino	□ Two or More Races	

Job Title: _____ Work Location: _____

Date First Entered NAD Denomination Service: _____

Type of Credential/License Held: _____

Have you previously worked for SECC? □ Yes □ No

Location: _____ Dates: _____

Are you currently working for SECC in another capacity? □ Yes □ No

Location: _____ Dates: _____

Are you currently receiving retirement from the North American Division? □ Yes □ No

Benefits Payroll Service Record

STATEMENT OF ETHICAL FOUNDATIONS FOR THE NORTH AMERICAN DIVISION AND ITS EMPLOYEES

Our Mission

The Seventh-day Adventist Church mission is to proclaim to all peoples the everlasting gospel, in the context of the three angels' messages of Revelation 14:6-12, leading them to accept Jesus as their personal Savior, and encouraging them to unite with His church and prepare for His soon return. Within the scope of this mission, the North American Division office exists to lead the Church in being a worldwide witness for God's kingdom and in making disciples of Jesus Christ.

Our Responsibilities

North American Division employees believe:

We are responsible first to God, our Creator. Individual and collective action must reflect His character and exhibit His love.

We are responsible to the communities in which we work and live and also to the world community. We accept the challenge to be exemplary individuals and corporate citizens. We support good works and charities. We encourage civic improvements, a better quality of life, security, health, and education for all.

We are responsible to our fellow church members. We accept accountability for sound leadership decisions and appropriate stewardship.

We are responsible to each other within the office complex. Every individual deserves to be treated with dignity and respect; to have his or her role and contribution valued and affirmed; to function in a safe working environment; to experience an atmosphere of challenge, open communication, and contentment.

Our Values

We value the *Bible* as the primary reference for life's direction and qualities.

We value *excellence* in all that we do.

We value *ethical and moral conduct* at all times and in all relationships.

We value *creativity and innovation* in the completion of our mission.

We value *honesty, integrity, and courage* as the foundation of all our actions.

We value the *trust* placed in us by colleagues and by the world Church membership.

We value *people* as children of God and therefore brothers and sisters of one family.

Ethical Responsibilities as Employer and Corporate Citizen

In pursuit of its mission, and while maintaining its responsibilities and adhering to its values, the General Conference operates under the following ethical guidelines:

Equal opportunity employment. Within the purview of laws permitting church membership as a condition of employment, and subject to denominational policies on positions requiring ministerial ordination, the North American Division will follow procedures to ensure equal opportunity of employment, remuneration, and advancement on the basis of job qualifications and performance.

Equity, fairness and non-discrimination. The North American Division will treat all individuals and groups with loving justice. It will not practice or condone discrimination with regard to race, national origin, gender, age, marital status, veteran status, or disability that does not prohibit performance of essential job functions.

Document voted by the General Conference 1999 Annual Council and at the 1999 North American Division Year-end Meeting.

Compliance with laws of the land. The North American Division will carry on its activities in compliance with the laws of the land provided these are not in contradiction to God's expressed will.

Loyalty and fulfillment of contractual obligations. The North American Division will fulfill the commitments it has entered into through authorized channels. Where misunderstandings arise regarding such commitments, the North American Division shall participate, with the parties concerned, in conflict resolution procedures within the organization before seeking the help of the wider community.

Atmosphere of safety and happiness. The North American Division is committed to providing a work environment that offers physical safety and security. It also strives to encourage and promote genuine happiness through the realization that every employee is valuable and every task, no matter how routine or unnoticed, is a service to God. The North American Division will continue to integrate worship, work, and celebration in a manner that acknowledges wholeness in life and relationships.

Respect for human dignity and individuality. The North American Division affirms and respects the uniqueness of every employee. It recognizes that a person's value surpasses the worth of his or her contribution to the organization. It believes that communal harmony and corporate objectives are enhanced rather than compromised by the broad mosaic of personalities, talents, skills, and viewpoints dedicated to the honor of Jesus Christ. The North American Division shall strive for communication that is timely, truthful, open, candid, and kind.

Ethical Responsibilities as Employees

We recognize that employment in the Seventh-day Adventist Church implies commitment to the organization's mission and concurrence with its responsibilities and values. We affirm that the employer-employee relationship grows within a reciprocity of mutual regard. Our reasonable service as employees includes the following ethical responsibilities:

Life consistent with church message and mission. While in the employ of the North American Division we will live in a manner consistent with the beliefs and values of the Church. We will uphold, in word and conduct, the teachings and principles held and advanced by the Seventh-day Adventist Church.

Respect for Church-owned assets. We will respect the property of our organization, including any intellectual property that is developed in the course of our employment. We will use the property, facilities, and resources solely for the benefit of our organization, unless otherwise permitted or when financial compensation for such use has been arranged.

Respect for colleagues. We will respect and uplift our fellow employees. We will refrain from intentionally placing another in a position of embarrassment, disrespect, or harassment. We will avoid all behavior that may be construed as sexually inappropriate. We will honor the privacy and guard the safety of others.

Efficiency and attention on the job. The hours of our employment shall be devoted to the work assignments entrusted to us. We will not use the employer's time for personal business or the advancement of personal interests unrelated to the work assigned by our supervisors. We will not deprive our employer by entering into other employment or activities which impair our performance for the North American Division while on the job. We will aspire to greater efficiency and the reduction of waste in time, effort, and resources.

Personal integrity in financial matters. We will not engage in theft or embezzlement of any kind including the misuse of expense accounts, falsification of time reports, or the misapplication of resources for which we are responsible.

Avoiding inappropriate influence. We acknowledge that the giving or receiving of business gifts can easily inject ulterior considerations in our work and employment relationships. Therefore the use of gifts, payments, or honoraria as incentives or rewards for a particular course of action is unacceptable. We will not offer gifts, favors, payments, or other forms of reward directly or indirectly in exchange for a specific gain or action.

Maintaining an ethical environment in the workplace. We accept the obligation of maintaining ethical standards in personal life and in the workplace. We believe it is our personal responsibility to report, through established confidential channels, any behavior that is inappropriate or which undermines the ethical environment in the office complex. We are prepared to be held accountable by our supervisors and peers for professional conduct representing the moral and ethical values of the Seventh-day Adventist Church.

Document voted by the General Conference 1999 Annual Council
and at the 1999 North American Division Year-end Meeting.

CONFERENCE EMPLOYEES
SOUTHEASTERN CALIFORNIA CONFERENCE
NORTH AMERICAN DIVISION
E 85/40 STATEMENT OF ACCEPTANCE

THIS DECLARATION applies, to the best of my knowledge, to all members of my immediate family (spouse, children, parents) and its provisions shall protect any organization affiliated with or subsidiary to the Southeastern California Conference hereafter known as SECC. In the event facts change in the future that may create a potential conflict of interest, I agree to notify SECC in writing.

1. I have read the Statement of Ethical Foundations and the policy on Conflict of Interest and/or Commitment.

2. I am in compliance with the SECC policy on conflict of interest and/or commitment as printed above.

3. Except as disclosed below:

    a. Neither I, nor my family, have a financial interest or business relationship which competes with or conflicts with the interests of SECC.

    b. Neither I, nor my family, have a financial interest in or have been an employee, officer, director, or trustee of, nor receive/have financial benefits either directly or indirectly from any enterprise (excluding less than five percent (5%) ownership in any entity with publicly traded securities) which is or has been doing business with or is a competitor of SECC.

    c. Neither I, nor my family, receive/have received any payments or gifts (other than of token value) from other denominational entities, suppliers, or agencies doing business with SECC.

    d. Neither I, nor my family, serve/have served as an officer, director, trustee, or agent of any organization affiliated with or subsidiary to SECC in any decision making process involving financial or legal interests adverse to SECC.

Disclosures:

1.

2.

3.

_____	_____	_____
Signature	Print Name	Date
_____	_____	
Job Title	Location	

EMPLOYEE SERVICE RECORD

First Name: _____ Social Security Number: _____

Middle Name: _____ Date of Birth: _____

Last Name: _____ Birthplace: _____

Maiden Name: _____ Citizenship: _____

Suffix: _____ Date of Ordination: _____

Address: _____ NAD Retirement Date: _____

City: _____ Date of Marriage: _____

State: _____ Spouse's Name: _____

Postal Code: _____ Spouse's Birthdate: _____

Phone Number: _____ Date Entered Denominational Service: _____

E-Mail Address: _____

Military Service: Country: _____ Branch: _____ Begin: _____ End: _____

Educational Record

Level of Education	Degree/Diploma Held	Institution	Year Received
College:			
Graduate:			
Doctoral:			
Other:			

Denominational Employment

(list the last place of denomination employment only)

Position/Type of Work: _____ Beginning Date: _____

Employing Organization: _____ Ending Date: _____

Conference Affiliation: _____

A record shall be maintained for all full-time employees, salaried employees working 50% or more, and hourly employees working 50% or more per year. Upon completion of this form, please return to the address listed below:

Southeastern California Conference
Human Resources Department
11330 Pierce Street / P. O. Box 8050
Riverside, CA 92515

Revision Date: 09 April 2008

Background Check Authorization for Employment

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

Former Name(s) and Dates Used: _____

Current Address Since: _____
(Mo/Yr) (Street) (City) (State/Zip)

Telephone Number: _____

Previous Address From: _____
(Mo/Yr) (Street) (City) (State/Zip)

Social Security Number: _____

Date Of Birth: _____

Drivers License Number/State: _____

Place of Employment: _____

The information contained in this application is correct to the best of my knowledge. I authorize Southeastern California Conference and its designated agents and representatives to conduct a comprehensive review of my background causing a consumer report and/or an investigative consumer report to be generated for employment and/or volunteer purposes. I understand that the scope of the consumer report/ investigative consumer report may include, but is not limited to the following areas: verification of social security number; current and previous residences; employment history, education background, character references; drug testing, civil and criminal history records from any criminal justice agency in any or all federal, state, county jurisdictions; driving records, birth records, and any other public records.

I further authorize any individual, company, firm, corporation, or public agency (including the Social Security Administration and law enforcement agencies) to divulge any and all information, verbal or written, pertaining to me, to Southeastern California Conference or its agents. I further authorize the complete release of any records or data pertaining to me which the individual, company, firm, corporation, or public agency may have, to include information or data received from other sources.

NAD Working Policy states for *Driver Record/Qualifications* that "All drivers shall be properly licensed and comply with all Federal, state and/or provincial laws for the class of vehicle being operated. The recommended minimum age for drivers shall be twenty-one (21) years. A minimum allowable age of nineteen (19) years old may be granted with the approval of the conference officers. The driving record (Motor Vehicle Record) of each driver shall be obtained from state/provincial records and reviewed on a regular basis. Drivers shall have an acceptable driving record during the previous three years with not more than two traffic citations and no at-fault accidents while driving any vehicle. When a driver does not meet the above driving standard, he/she shall not be assigned to or retained for a driving position."

***Southeastern California Conference and its designated agents and representatives shall maintain all information received from this authorization in a confidential manner in order to protect the applicants personal information, including, but not limited to, addresses, social security numbers, and dates of birth.

Notice:
If you wish to receive a copy of your Background Check Report, please initial here: _____

Signature: _____ Date: _____

Southeastern California Conference
Human Resources Department

Church Membership Verification Form

Name:	
Previous/Maiden Name:	
Address:	
Date of Birth:	
Church Where Membership is Held: *If church is not within SECC, which conference?	
Membership by:	☐ Baptism ☐ Profession of Faith
Pastor's Name:	
Previous Church Membership:	
Form Completed by:	
Date Form Completed:	

*If your membership is not within SECC please have your church provide a letter of verification stating that you are currently a baptized member in good standing.

Office Use Only:

Membership Verified by:	
Date Membership Verified:	

Return this form to:
SECC Human Resources Dept. Attention: Brooke Hess
P.O. Box 79990 Riverside, CA 92513-1990
Brooke.hess@seccsda.org 951-509-2353 (Phone) 951-509-2395 (fax)

JOB HAZARD ASSESSMENT SURVEY

Description of Duties

In order to assign appropriate training for the employees at the church or in the department, please complete this form for each position. This form must be completed as part of the New Employee Packet.

Supervising Site Location _____

Position _____

Employee Serving in this Position _____

Essential Duties and Responsibilities

Please provide a list of essential duties and responsibilities for this position. Attach additional sheet as necessary or attach existing job description if available.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Please select and check next to each item listed below that pertains to this position:

- ☐ This position requires, frequent or infrequent use of a ladder.
- ☐ The position requires lifting or moving objects, even if infrequently.
- ☐ This position works with chemicals, such as cleaning products, copy machine toner, paint, paint thinner, etc.
- ☐ This position works with power tools (i.e. lawn mowers, saws, drills, grinders).
- ☐ This position works with installing and/or repairing electrical wiring, or comes into contact with electrical wiring, boxes, etc.
- ☐ This position may come in contact with blood borne pathogens, such as cleaning the restrooms or working with food.
- ☐ This position requires repetitive movement or prolonged positions (i.e. sitting, working primarily with a computer).

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility
Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt"** until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
_____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
_____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ❑ Check if you agree to receive notices about your claim by email only. ❑ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.
You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*
9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.*_____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
_____
16. Insurance Policy Number. *El número de la póliza de Seguro.*_____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

❑ Employer copy/*Copia del Empleador* ❑ Employee copy/*Copia del Empleado* ❑ Claims Administrator/*Administrador de Reclamos* ❑ Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME: SOUTHEASTERN CALIFORNIA CONFERENCE OF SEVENTH-DAY ADVENTISTS (SECC)

1a. Policy Number

2. MAILING ADDRESS: (Number, Street, City, Zip): PO BOX 79990 RIVERSIDE, CA 92513

2a. Phone Number

3. LOCATION if different from Mailing Address (Number, Street, City and Zip): 11330 PIERCE STREET RIVERSIDE, CA 92505

3a. Location Code

4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.: 1) CHURCH 2) SCHOOL 3) SECC OFFICE

5. State unemployment insurance acct.no

6. TYPE OF EMPLOYER: ☑ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)

8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM

9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM

10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)

11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No

12. DATE LAST WORKED (mm/dd/yy)

13. DATE RETURNED TO WORK (mm/dd/yy)

14. IF STILL OFF WORK, CHECK THIS BOX: ☐

15. PAID FULL DAYS WAGES FOR DATE OF NJURY OR LAST DAY WORKED? ☐ Yes ☐ No

16. SALARY BEING CONTINUED? ☐ Yes ☐ No

17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)

18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)

19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning

20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)

20a. COUNTY

21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No

22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.

23. Other Workers injured or ill in this event? ☐ Yes ☐ No

24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold

25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.

26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY

27. Name and address of physician (number, street, city, zip)

27a. Phone Number

28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)

28a. Phone Number

29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.

Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME

31. SOCIAL SECURITY NUMBER

32. DATE OF BIRTH (mm/dd/yy)

33. HOME ADDRESS (Number, Street, City,Zip)

33a. PHONE NUMBER

34. SEX ☐ Male ☐ Female

35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)

36. DATE OF HIRE (mm/dd/yy)

37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours

37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal

37b. UNDER WHAT CLASS CODE OF YOUR POLICY WAGES ASSIGNED

38. GROSS WAGES/SALARY $ _____ per _____

39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)

Signature & Title

Date (mm/dd/yy)

Please do not use this column

CASE NUMBER

OWNERSHIP

INDUSTRY

OCCUPATION

SEX

AGE

DAILY HOURS

DAYS PER WEEK

WEEKLY HOURS

WEEKLY WAGE

COUNTY

NATURE OF INJURY

PART OF BODY

SOURCE

EVENT

SECONDARY SOURCE

EXTENT OF INJURY

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

VOLUNTEER

RELEASE, WAIVER AND INDEMNITY AGREEMENT

I request to volunteer my services to the Southeastern California Conference of Seventh-day Adventists ("Conference") as part of their Volunteer Program ("Program"). I hereby acknowledge, understand and agree that by participating in the Program, including entering premises and facilities, I may be exposed to risks of damage to my person or property, including but not limited to, illness, injury to my person or personal property, accident or death. I understand, acknowledge and agree that such damage may be caused, either directly or indirectly, in whole or in part, by my participation in the Program.

I HEREBY AGREE that I am fully aware of the risks and hazards inherent in participating in the Program, and I agree to accept and assume full responsibility for any and all risks of damage, injury, illness or death resulting to me or my property while participating in the Program. _____ (**Initial**)

I HEREBY AGREE, in consideration for Conference allowing me to participate in the Program, that I, my personal representative, heirs, next-of-kin and assigns (collectively the "Releasors") hereby release, waive, discharge and covenant not to sue Conference and their officials, officers, employees, volunteers and agents from and for any and all liability for any loss or damage to me or the other Releasors, and from and for any claim or demands therefore on account of injury to the person or property of me or the other Releasors, including illness and death, whether caused by the negligence of me or the other Releasors or otherwise while I participate in the Program, whether the risks are known or unknown to me. _____ (**Initial**)

I HEREBY AGREE to defend, indemnify, save and hold free and harmless the Conference and their officials, officers, employees, volunteers and agents from any and all liability from loss, damage, cost or injury, including wrongful death, to any property or persons, including third parties, in any manner arising out of or incident to any acts, omissions or willful misconduct of me while I participate in the Program, including without limitation the payment of attorney's fees. Further, I shall defend at my own expense, including attorney's fees, the Conference and their officials, officers, employees, volunteers and agents in any action or proceeding, legal, administrative or otherwise, based upon such acts, omissions or willful misconduct. _____ (**Initial**)

I HEREBY AGREE that I shall not be considered an employee of the Conference for any purpose, including, but not limited to, wages, workers' compensation, retirement benefits, health benefits, seniority, sick leave and vacation leave. _____ (**Initial**)

I HEREBY AGREE that this release, waiver and indemnity agreement is intended to be as board and inclusive as is permitted by the laws of the State of California, and that if any portion

thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. _____ (**Initial**)

I HEREBY AGREE that I have read and voluntarily sign this release, waiver and indemnity agreement, and further agree that no oral representations, statements or inducements apart from the foregoing written agreement have been made. _____ (**Initial**)

I HEREBY AGREE that this release, waiver and indemnity agreement shall be binding on me and my personal representatives, heirs, assigns and next-of-kin. _____ (**Initial**)

I HEREBY AGREE and acknowledge that I will abide by all safety requirements and instructions given to me by any and all Conference personnel during my participation in the Program. _____ (**Initial**)

I HAVE CAREFULLY READ, UNDERSTAND, ACKNOWLEDGE AND AGREE TO THIS RELEASE, WAIVER AND INDEMNITY AGREEMENT. I UNDERSTAND THAT I AM GIVING UP VALUABLE LEGAL RIGHTS BY SIGNING THIS RELEASE, WAIVER AND INDEMNITY AGREEMENT, AND THAT THIS AGREEMENT REPRESENTS A CONTRACT BETWEEN MYSELF AND THE CONFERENCE. I HAVE AGREED TO SIGN THIS AGREEMENT OF MY OWN FREE WILL.

I UNDERSTAND THAT I MAY SEEK THE ADVICE OF AN ATTORNEY IN ANY MANNER CONNECTED WITH THIS RELEASE, WAIVER AND INDEMNITY AGREEMENT BEFORE I SIGN THIS AGREEMENT. I UNDERSTAND THAT I MAY CALL AN ATTORNEY REFERRAL SERVICE OR LEGAL AID OFFICE IN ORDER TO OBTAIN AN ATTORNEY OR LEGAL ADVICE.

I understand that volunteers are urged to carry insurance (life, disability) and the appropriate hospitalization insurance before entering into the Program.

Dated: _____ _____

Applicant's Signature

Dated: _____ _____

Signature of Legal Guardian
(If applicant is a minor)

STATE OF CALIFORNIA DEPARTMENT OF EDUCATION

STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR WORK PERMIT–CERTIFICATE OF AGE

CDE B1-1 (Rev. 07-10)

A "STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR WORK PERMIT–CERTIFICATE OF AGE" form (CDE B1-1) shall be completed in accordance with California *Education Code* 49162 and 49163 as notification of intent to employ a minor. This form is also a Certificate of Age pursuant to California *Education Code* 49114.

(Print Information)

Minor's Information

Minor's Name *(First and Last)* | Home Phone

Birth Date | Social Security Number | Grade | Age

Home Address | City | Zip Code

School Information

School Name | School Phone

School Address | City | Zip Code

To be filled in and signed by employer. (Please review the General Summary of Minors' Work Regulations on reverse.)

Business Name or Agency of Placement | Business Phone | Supervisor's Name

Business Address | City | Zip Code

Describe nature of work to be performed:

In compliance with California labor laws, this employee is covered by worker's compensation insurance. This business does not discriminate unlawfully on the basis of race, ethnic background, religion, sex, sexual orientation, color, national origin, ancestry, age, physical handicap, or medical condition. I hereby certify that, to the best of my knowledge, the information herein is correct and true.

Employer's Name *(Print First and Last)* | Employer's Signature | Date

To be filled in and signed by parent or legal guardian

This minor is being employed at the place of work described with my full knowledge and consent. I hereby certify that to the best of my knowledge and belief, the information herein is correct and true. I request that a work permit be issued.

Parent or Legal Guardian's Name *(Print First and Last)* | Parent or Legal Guardian's Signature | Date

For authorized work permit issuer use ONLY

Maximum number of hours of employment when school is in session:

Mon	Tue	Wed	Thu	Fri	Sat	Sun	Total

Proof of Minor's Age *(Evidence Type)*

Verifying Authority's Name and Title *(Print)*

Verifying Authority's Signature

Check Permit Type:

- ☐ *Full-time
- ☐ **Workability
- ☐ Restricted
- ☐ General
- ☐ ***Work Experience Education, Vocational Education, or Personal Attendant

EC 49130 | **Permit Type defined by local school | ***Special Education Grant

Copy–District or County Superintendent; Employer; Parent or Legal Guardian **(Over)**

STATE OF CALIFORNIA DEPARTMENT OF EDUCATION

STATEMENT OF INTENT TO EMPLOY A MINOR AND REQUEST FOR WORK PERMIT—CERTIFICATE OF AGE

CDE B1-1 (Rev. 07-10)

General Summary of Minors' Work Regulations

FLSA-Federal Labor Standards Act, CDE-California Department of Education, *EC*-California *Education Code*, *LC*-California *Labor Code*, *CFR*-California Federal Regulations

- **If federal laws, state laws, and school district policies conflict, the more restrictive law (the one most protective of the minor) prevails. (FLSA)**
- Employers of minors required to attend school must complete a "Statement of Intent to Employ a Minor and Request for Work Permit" (CDE B1-1) for the school attendance for each such minor. (*EC* 49162)
- Employers must retain a "Permit to Employ and Work" (CDE B1-4) for each such minor. *(EC* 49161)
- Work permits (CDE B1-4) must be retained for three years and be available for inspection by sanctioned authorities at all times. (*EC* 49164)
- A work permit (CDE B1-4) must be revoked whenever the issuing authority determines the employment is illegal or is impairing the health or education of the minor. (*EC* 49164)
- A day of rest from work is required in every seven days, and shall not exceed six days in seven. (*LC* 551, 552)

Minors under the age of 18 may not work in environments declared hazardous or dangerous for young workers, examples listed below: (*LC* 1294.1 and 1294.5, 29 *CFR* 570 Subpart E)

1. Explosive exposure
2. Motor vehicle driving/outside helper
3. Roofing
4. Logging and sawmilling
5. Power-driven woodworking machines
6. Radiation exposure
7. Power-driven hoists/forklifts
8. Power-driven metal forming, punching, and shearing machines
9. Power saws and shears
10. Power-driving meat slicing/processing machines

HOURS OF WORK

16 & 17 Year Olds	**14 & 15 Year Olds**	**12 & 13 Year Olds**
Must have completed 7th grade to work while school is in session. (*EC* 49112)	Must have completed 7th grade to work while school is in session (*EC* 49112)	Labor laws generally prohibit non-farm employment of children younger than 14. Special rules apply to agricultural work, domestic work, and the entertainment industry. (*LC* 1285–1312)
School In Session		
4 hours per day on any schoolday (*EC* 49112; 49116; *LC* 1391) 8 hours on any non-schoolday or on any day preceding a non-schoolday. (*EC* 49112; *LC* 1391) 48 hours per week (*LC* 1391) WEE students & personal attendants may work more than 4 hours on a schoolday, but never more than 8. (*EC* 49116; *LC* 1391, 1392)	3 hours per schoolday outside of school hours (*EC* 49112, 49116; *LC* 1391) 8 hours on any non-schoolday No more than 18 hours per week (*EC* 49116; *LC* 1391) WEE students may work during school hours & up to 23 hours per week. (*EC* 49116; *LC* 1391)	2 hours per schoolday and a maximum of 4 hours per week. (*EC* 49112)
School Not In Session		
8 hours per day (*LC* 1391, 1392) 48 hours per week (*LC* 1391)	8 hours per day (*LC* 1391, 1392) 40 hours per week (*LC* 1391)	8 hours per day (*LC* 1391, 1392) 40 hours per week (*LC* 1391)
Spread of Hours		
5 a.m.–10 p.m. However, until 12:30 a.m. on any evening preceding a non-schoolday (*LC* 1391) WEE students, with permission, until 12:30 a.m. on any day (*LC* 1391.1) Messengers: 6 a.m.–9 p.m.	7 a.m.–7 p.m., except that from June 1 through Labor Day, until 9 p.m. (*LC* 1391)	7 a.m.–7 p.m., except that from June 1 through Labor Day, until 9 p.m. (*LC* 1391)

For more information about child labor laws, contact the U.S. Department of Labor at http://www.dol.gov/, and the State of California Department of Industrial Relations, Division of Labor Standards Enforcement at http://www.dir.ca.gov/DLSE/dlse.html.

Do Not Staple 6969

Form 1096 Department of the Treasury Internal Revenue Service	Annual Summary and Transmittal of U.S. Information Returns	OMB No. 1545-0108 2017

FILER'S name
SAMPLE - Seventh-day Adventist Church

Street address (including room or suite number)
12345 Hope Street

City or town, state or province, country, and ZIP or foreign postal code
Anytown, CA 92146

For Official Use Only

Name of person to contact	Telephone number
Joe Treasurer	(951) 509-1234
Email address	**Fax number**
Joe.Treasurer@anywhere.org	(951)509-4321

1 Employer identification number	2 Social security number	3 Total number of forms	4 Federal income tax withheld	5 Total amount reported with this Form 1096
91-1234567		2	$	$ 2,100.00

6 Enter an "X" in only one box below to indicate the type of form being filed.

7 Form 1099-MISC with NEC in box 7, check . . . . . ▶ X

W-2G 32	1097-BTC 50	1098 81	1098-C 78	1098-E 84	1098-Q 74	1098-T 83	1099-A 80	1099-B 79	1099-C 85	1099-CAP 73	1099-DIV 91	1099-G 86	1099-INT 92	1099-K 10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

1099-LTC 93	1099-MISC 95	1099-OID 96	1099-PATR 97	1099-Q 31	1099-QA 1A	1099-R 98	1099-S 75	1099-SA 94	3921 25	3922 26	5498 28	5498-ESA 72	5498-QA 2A	5498-SA 27
☐	A↑ A↓ X	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Return this entire page to the Internal Revenue Service. Photocopies are not acceptable.

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and, to the best of my knowledge and belief, they are true, correct, and complete.

Signature ▶ **Title ▶** Treasurer **Date ▶**

Instructions

Future developments. For the latest information about developments related to Form 1096, such as legislation enacted after it was published, go to *www.irs.gov/form1096.*

Reminder. The only acceptable method of electronically filing information returns listed on this form in box 6 with the IRS is through the FIRE system. See Pub. 1220.

Purpose of form. Use this form to transmit paper Forms 1097, 1098, 1099, 3921, 3922, 5498, and W-2G to the Internal Revenue Service.

Caution: If you are required to file 250 or more information returns of any one type, you must file electronically. If you are required to file electronically but fail to do so, and you do not have an approved waiver, you may be subject to a penalty. For more information, see part F in the 2017 General Instructions for Certain Information Returns.

Forms 1099-QA and 5498-QA can be filed on paper only, regardless of the number of returns.

Who must file. The name, address, and TIN of the filer on this form must be the same as those you enter in the upper left area of Forms 1097, 1098, 1099, 3921, 3922, 5498, or W-2G. A filer is any person or entity who files any of the forms shown in line 6 above.

Enter the filer's name, address (including room, suite, or other unit number), and TIN in the spaces provided on the form.

When to file. File Form 1096 as follows.

- With Forms 1097, 1098, 1099, 3921, 3922, or W-2G, file by February 28, 2018.

Caution: File Form 1099-MISC by January 31, 2018, if you are reporting **nonemployee compensation** in box 7. Also, check box 7 above.

- With Forms 5498, file by May 31, 2018.

Where To File

Send all information returns filed on paper with Form 1096 to the following.

If your principal business, office or agency, or legal residence in the case of an individual, is located in	Use the following three-line address
Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, West Virginia	Department of the Treasury Internal Revenue Service Center Austin, TX 73301

Alaska, California, Colorado, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Washington, Wisconsin, Wyoming	Department of the Treasury Internal Revenue Service Center Kansas City, MO 64999

If your legal residence or principal place of business is outside the United States, file with the Department of the Treasury, Internal Revenue Service Center, Austin, TX 73301.

Transmitting to the IRS. Group the forms by form number and transmit each group with a separate Form 1096. For example, if you must file both Forms 1098 and 1099-A, complete one Form 1096 to transmit your Forms 1098 and another Form 1096 to transmit your Forms 1099-A. You need not submit original and corrected returns separately. Do not send a form (1099, 5498, etc.) containing summary (subtotal) information with Form 1096. Summary information for the group of forms being sent is entered only in boxes 3, 4, and 5 of Form 1096.

Box 1 or 2. Make an entry in either box 1 or 2; not both. Individuals not in a trade or business must enter their social security number (SSN) in box 2; sole proprietors and all others must enter their employer identification number (EIN) in box 1. However, sole proprietors who do not have an EIN must enter their SSN in box 2. Use the same EIN or SSN on Form 1096 that you use on Forms 1097, 1098, 1099, 3921, 3922, 5498, or W-2G.

Box 3. Enter the number of forms you are transmitting with this Form 1096. Do not include blank or voided forms or the Form 1096 in your total. Enter the number of correctly completed forms, not the number of pages, being transmitted. For example, if you send one page of three-to-a-page Forms 1098-E with a Form 1096 and you have correctly completed two Forms 1098-E on that page, enter "2" in box 3 of Form 1096.

Box 4. Enter the total federal income tax withheld shown on the forms being transmitted with this Form 1096.

Box 5. No entry is required if you are filing Form 1098-T, 1099-A, or 1099-G. For all other forms, enter the total of the amounts from the specific boxes of the forms listed below.

Form W-2G	Box 1
Form 1097-BTC	Box 1
Form 1098	Boxes 1 and 6
Form 1098-C	Box 4c
Form 1098-E	Box 1
Form 1098-Q	Box 4
Form 1099-B	Boxes 1d and 13
Form 1099-C	Box 2
Form 1099-CAP	Box 2
Form 1099-DIV	Boxes 1a, 2a, 3, 8, 9, and 10
Form 1099-INT	Boxes 1, 3, 8, 10, 11, and 13
Form 1099-K	Box 1a
Form 1099-LTC	Boxes 1 and 2
Form 1099-MISC	Boxes 1, 2, 3, 5, 6, 7, 8, 10, 13, and 14
Form 1099-OID	Boxes 1, 2, 5, 6, and 8
Form 1099-PATR	Boxes 1, 2, 3, and 5
Form 1099-Q	Box 1
Form 1099-QA	Box 1
Form 1099-R	Box 1
Form 1099-S	Box 2
Form 1099-SA	Box 1
Form 3921	Boxes 3 and 4
Form 3922	Boxes 3, 4, and 5
Form 5498	Boxes 1, 2, 3, 4, 5, 8, 9, 10, 12b, 13a, and 14a
Form 5498-ESA	Boxes 1 and 2
Form 5498-QA	Boxes 1 and 2
Form 5498-SA	Box 1

Corrected returns. For information about filing corrections, see the 2017 General Instructions for Certain Information Returns. Originals and corrections of the same type of return can be submitted using one Form 1096.

9595 ☐ VOID ☐ CORRECTED

PAYER'S name, street address, city or town, province or state, country, ZIP or foreign postal code, and telephone no.	1 Rents	OMB No. 1545-0115	Miscellaneous Income
SAMPLE - Seventh-day Adventist Church 12345 Hope Street Anytown, CA 92641	$	2013	
	2 Royalties $	Form 1099-MISC	
	3 Other income $	4 Federal income tax withheld $	Copy A For Internal Revenue Service Center
PAYER'S federal identification number: 91-2165741 / RECIPIENT'S identification number: 123-45-6789	5 Fishing boat proceeds $	6 Medical and health care payments $	File with Form 1096.
RECIPIENT'S name: Joseph Smith	7 Nonemployee compensation $ 1,500.00	8 Substitute payments in lieu of dividends or interest $	For Privacy Act and Paperwork Reduction Act Notice, see the 2013 General Instructions for Certain Information Returns.
Street address (including apt. no.): 13356 Third Street	9 Payer made direct sales of $5,000 or more of consumer products to a buyer (recipient) for resale ► ☐	10 Crop insurance proceeds $	
City or town, province or state, country, and ZIP or foreign postal code: Loma Linda, CA 92354	11 Foreign tax paid $	12 Foreign country or U.S. possession	
Account number (see instructions) / 2nd TIN not. ☐	13 Excess golden parachute payments $	14 Gross proceeds paid to an attorney $	
15a Section 409A deferrals $	15b Section 409A income $	16 State tax withheld $	17 State/Payer's state no.	18 State income $

Form 1099-MISC Cat. No. 14425J www.irs.gov/form1099misc Department of the Treasury - Internal Revenue Service

Do Not Cut or Separate Forms on This Page — Do Not Cut or Separate Forms on This Page

Independent Contractor Reporting Requirements

Background

California State Senate Bill 542 was passed during the 1999-2000 legislative session and signed into law. This law requires businesses and government entities to report specified information to the Employment Development Department (EDD) on independent contractors.

Who Must Report

Any business or government entity (defined as a "service-recipient") that is required to file a federal Form 1099-MISC for services performed by an independent contractor (defined as a "service-provider") must report. A service-recipient means any individual, person, corporation, association, or partnership, or agent thereof, doing business in this State, deriving trade or business income from sources within this State, or in any manner in the course of trade or business subject to the laws of this State.

An independent contractor is defined as an individual who is not an employee of the business or government entity for California purposes and who receives compensation or executes a contract for services performed for that business or government entity either in or outside of California.

Benefits of the Program

The information you provide to EDD will increase child support collection by helping to locate parents who are delinquent in their child support obligations.

Effective Date

January 1, 2001.

When the Information Must Be Reported

You must report to EDD within twenty (20) days of EITHER making payments totaling $600 or more OR entering into a contract for $600 or more with an independent contractor in any calendar year, whichever is earlier.

What Information Must Be Reported

You are required to provide the following information that applies.

Business or government entity's (service-recipient):

- Federal employer identification number
- California employer account number
- Social security number
- Business name, address, and telephone number

Independent contractor's (service-provider):

- First name, middle initial and last name
- Social security number
- Address
- Start date of contract (if no contract, date payments equal $600 or more)
- Amount of contract, including cents (if applicable)
- Contract expiration date (if applicable)
- Ongoing contract (check box if applicable)

General Information

Report independent contractor information on the *Report of Independent Contractor(s)* (DE 542) form or online with EDD's expanded e-Services for Business. To obtain forms and/or information, call our hotline number (916) 657-0529. You may also call our toll-free number (888) 745-3886, visit your local Employment Tax Office listed in your local telephone directory in the State Government section under "Employment Development Department," or online.

Where to Send Reports

Employment Development Department
P.O. Box 997350, Document Management Group, MIC 96
Sacramento, CA 95899-7350

Información en Español

Self-Service Options
- e-Services for Business
- Register as an Employer
- File and Pay Taxes
- Rates and Withholding
- Forms and Publications

Top Links This Month
- e-Services for Business Enrollment Process
- e-Services for Business Information
- File and Pay Taxes
- Forms and Publications
- Rates and Withholding

FAQs
- Payroll Taxes FAQs

Contact Us
- About Payroll Taxes

Employment Development Department
State of California

REPORT OF INDEPENDENT CONTRACTOR(S)

See detailed instructions on reverse side. Please type or print.

05420101

SERVICE-RECIPIENT (BUSINESS OR GOVERNMENT ENTITY):

DATE | FEDERAL ID NUMBER | CA EMPLOYER ACCOUNT NUMBER | SOCIAL SECURITY NUMBER

SERVICE-RECIPIENT NAME / BUSINESS NAME | CONTACT PERSON

ADDRESS | PHONE NUMBER

CITY | STATE | ZIP CODE

SERVICE-PROVIDER (INDEPENDENT CONTRACTOR):

FIRST NAME | MI | LAST NAME

SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | UNIT/APT

CITY | STATE | ZIP CODE

START DATE OF CONTRACT (M M D D Y Y) | AMOUNT OF CONTRACT | CONTRACT EXPIRATION DATE (M M D D Y Y) | CHECK HERE IF CONTRACT IS ONGOING

27.

FIRST NAME | MI | LAST NAME

28. Hospitalized as an inpatient overnight? | 30. EMPLOYEE NAME

SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | UNIT/APT

31. SOCIAL SECURITY NUM | 32. DATE OF B | 33. HOME ADDRESS (Number, Street, City,Zip)

CITY | STATE | ZIP CODE

36. DA

START DATE OF CONTRACT (M M D D Y Y) | AMOUNT OF CONTRACT | CONTRACT EXPIRATION DATE (M M D D Y Y) | CHECK HERE IF CONTRACT IS ONGOING

FIRST NAME | MI | LAST NAME

SOCIAL SECURITY NUMBER | STREET NUMBER | STREET NAME | UNIT/APT

CITY | STATE | ZIP CODE

START DATE OF CONTRACT (M M D D Y Y) | AMOUNT OF CONTRACT | CONTRACT EXPIRATION DATE (M M D D Y Y) | CHECK HERE IF CONTRACT IS ONGOING

Fast, Easy, and Convenient!
Visit the EDD's website at www.edd.ca.gov

MAIL TO: Employment Development Department • P.O. Box 997350, MIC 96 • Sacramento, CA 95899-7350
or Fax to 916-319-4410

INSTRUCTIONS FOR COMPLETING THE REPORT OF INDEPENDENT CONTRACTOR(S)

WHO MUST REPORT:

Any business or government entity (defined as a "Service-Recipient") that is required to file a federal Form 1099-MISC for service performed by an independent contractor (defined as a "Service-Provider") must report. You must report to the Employment Development Department (EDD) within twenty (20) days of EITHER making payments of $600 or more OR entering into a contract for $600 or more with an independent contractor in any calendar year, whichever is earlier. This information is used to assist state and county agencies in locating parents who are delinquent in their child support obligations.

An independent contractor is further defined as an individual who is not an employee of the business or government entity for California purposes and who receives compensation or executes a contract for services performed for that business or government entity either in or outside of California. For further clarification, request *Information Sheet: Employment Work Status Determination* (DE 231ES). See below for information on how to obtain additional forms.

YOU ARE REQUIRED TO PROVIDE THE FOLLOWING INFORMATION THAT APPLIES:

Service-Recipient (Business or Government Entity)

- Federal Employer Identification Number
- California employer account number
- Social Security Number
- Service-recipient name/business name, address, and phone number

Service-Provider (Independent Contractor)

- First name, middle initial, and last name
- Social Security Number
- Address
- Start date of contract (if no contract, date payments equal $600 or more)
- Amount of contract including cents (if applicable)
- Contract expiration date (if applicable)
- Ongoing contract (check box if applicable)

HOW TO COMPLETE THIS FORM:

If you use a typewriter or printer, ignore the boxes and type in UPPER CASE as shown. Do not use commas or periods.

FIRST NAME	MI	LAST NAME
IMOGENE	A	SAMPLE

SOCIAL SECURITY NUMBER	STREET NUMBER	STREET NAME	UNIT / APT.
xxxxxxxxx	12345	MAIN STREET	301

If you **handwrite this form**, print each letter or number in a separate box as shown. Do not use commas or periods.

FIRST NAME	MI	LAST NAME
I M O G E N E	A	S A M P L E

SOCIAL SECURITY NUMBER	STREET NUMBER	STREET NAME	UNIT / APT.
X X X X X X X X X	1 2 3 4 5	M A I N S T R E E T	3 0 1

ADDITIONAL INFORMATION:

If you have questions concerning the independent contractor reporting requirement, you may visit the EDD's website at **www.edd.ca.gov/Payroll_Taxes/Independent_Contractor_Reporting.htm**, call the New Employee Registry and Independent Contractor Reporting phone line at 916-657-0529, call the Taxpayer Assistance Center at 888-745-3886, or visit your local Employment Tax Office listed in the *California Employer's Guide* (DE 44).

To obtain additional DE 542 forms:

- Visit the website at **www.edd.ca.gov/Forms/default.asp**
- For 25 or more forms, call 916-322-2835
- For less than 25 forms, call 916-657-0529 or call 888-745-3886

HOW TO REPORT:

For a faster, easier, and more convenient method of reporting your DE 542 information, you are encouraged to report online using the EDD's e-Services for Business. Visit the website at **https://eddservices.edd.ca.gov** to choose the option that is best for you.

To file a DE 542 form, complete the information in the boxes provided on the form and fax to 916-319-4410 or mail to the following address:

EMPLOYMENT DEVELOPMENT DEPARTMENT
P.O. Box 997350, MIC 96
Sacramento, CA 95899-7350

HONORARIUM AND OTHER PAYMENTS TO NON-SECC-EMPLOYEE SERVICE PROVIDERS

INFORMATION FORM

For Year 20_____

(Please read reverse side for complete instructions)

*For **non-SECC employees:***

a. Obtain required information in items #2-7from person receiving payment
b. Churches and schools: Please use this form or a Form W-9 for your records and file a Form 1099 Misc. directly with the IRS.

(1) Payment Made By: _____ _____
Name of Church/School/Dept. etc. *Name of person filling out form*

(2) Unincorporated service provider: _____
Name of person or business receiving payment

(3) DBA(Doing Business As), if applicable: _____

(4) Type of Entity (Check One):

___ Individual/Sole Proprietor __ Corporation
___ Partnership __ Other (please describe) _____

(5) Address: _____
P.O. Box/Street *City* *State* *Zip*

(6) Phone Number: _____

(7) Taxpayer Identification Number:
Social Security # _____ - _____ - _____ **or** Employer Identification #_____

(8) Payment Amount $ _____ (9) Payment Date: _____ (10) Check #_____

(1 l)If cash is paid, signature of person receiving cash: _____
Signature of person receiving cash

(12)Brief description of service: _____

(13)1 certify that my tax payer identification number as listed above is correct and that I am not subject to

backup withholding _____ Date:_____
Signature of person receiving payment

HONORARIUM AND OTHER PAYMENTS TO NON-EMPLOYEE SERVICE PROVIDERS

INSTRUCTIONS

(For persons and entities who receive payments for services (e.g. honorariums, fees, etc.). Payments to SECC employees **must** be processed through conference payroll.

Law Under Internal Revenue Code Section [6041A(a)], all payments aggregating $600 or more during a calendar year, paid to a non-employee, unincorporated service provider in the course of a trade or business (except doctors and lawyers), must be reported to the IRS on a Form 1099 Misc. All payments to doctors and lawyers must be reported on a Form 1099 Misc. Payments for merchandise, telephone, freight, storage, etc., are excluded. The church's status as a non-profit organization does not exempt it from these requirements.

Definition of a Service Provider

A service provider is a person or business who receives honorariums, fees, commissions, or other forms of compensation for services rendered. Examples of service providers are:

Attorneys	*Repair persons*	*Commercially contracted Janitor/Custodian*
Architects	*Guest lecturers and speakers*	*Clergy (SDA or not, given as Honorariums)*
Accountants	*Musicians and entertainers*	*Sub-contractor (painter, carpenter etc.)*

Note: Most Janitors/Custodians, etc. in SECC churches/schools are considered employees with wages being paid through conference payroll. If you want to know if your custodian, etc. can be paid as an independent contractor, contact Human Resources. Also, you do not have to report payments to any corporations (except corporations providing medical care and incorporated law firms).

Note to Church/School Treasurers: Please ask your non-SECC-employee service provider to complete items 2-7 (over) or complete IRS Form W-9. Issue checks only when the required information is **complete.**

Conference Policy

Each church and school is required to obtain an Employer Identification Number (EIN). Using the EIN, churches and schools are required to issue 1099-Misc. Forms at the end of each calendar year to each non-employee service provider for payments totaling $600 or more in one calendar year. Churches and schools who fail to report may be responsible for IRS penalties.

IRS Penalties

Penalties will be assessed for failure to file correct information. There are additional penalties for failure to file by the due date (January 31 of the year following the payments), for failure to include all the required information, or for including incorrect TIN, payee surname, or payment amount. Penalties are $15 to $50 per reporting form, with maximum penalties $25,000 to $250,000 per year.

HONORARIUM FOR SECC EMPLOYEES

REQUEST FORM

PAY TO: _____

_____

_____

_____

AMOUNT: **$** _____

❑ Add to payroll ❑ Add to wages for tax reporting purposes only. Already paid.

DESCRIPTION: _____

_____

_____

_____

REQUESTING ORGANIZATION: _____

ADDRESS: _____

_____

PHONE #: _____

E-MAIL: _____

AFFIRMATION: We understand that by submitting this request, the above honorarium will be added to the SECC employee's bi-weekly payroll, and will be subject to all tax and other reporting requirements, and our organization will be billed for the resulting charges.

REQUESTED BY: _____ DATE: _____

AUTHORIZED BY: _____ DATE: _____
(Business Manager, Treasurer or Pastor)

Email to payroll@seccsda.org or FAX to 951-509-2393

Adventist Risk Management, Inc.®

CLAIM REPORTING

24/7 Hotline: (888) 951-4276 (press 2)

CLAIMS@ADVENTISTRISK.ORG

Claim FORMS are available at www.adventistrisk.org > Forms > Claims

DO NOT WAIT TO FILE YOUR CLAIM – Provide as much information as you can but do not delay filing your claim because you are waiting on additional information.

DUTY TO PROTECT – You have a duty to protect your property. If you have a situation where the damage from a loss may cause additional risk or damage it is important to mitigate the loss. For example, this may mean turning off the water if you have broken pipes and calling a clean-up company. Do not hesitate to take care of your property. It will need to be done whether you have insurance coverage or not. Waiting will only make the problem worse.

HOW THE CLAIMS PROCESS WORKS

Your claims examiner will help you understand the process in greater detail; however, the process follows this model:

1. **FILE CLAIM** - A claim is filed with ARM, you have provided as much information as possible and the claim examiner helps you know what additional information is necessary. You work to provide all required information as quickly as possible. **VERIFY THAT THE CONTACT INFORMATION YOU PROVIDE IS CURRENT.**

2. **INVESTIGATION** - The claims examiner, often with the help of an on-site adjuster, conducts the investigation.

3. **RESULT** - When the investigation is complete the claims examiner will relate the result to you (if you are the designated contact person). The result may be that the claim is accepted, partially paid or denied. This is determined by the terms of the insurance policy, the deductible or perhaps a sublimit that applies to that type of loss.

4. **PAYMENT** - Adventist Risk Management will issue a payment for the loss.
   - For property losses the payment goes to the insured (Conference).
   - For automobile losses the payment will go to the body shop or claimant.
   - For personal injury losses the payment will go either to the claimant or to the provider, according to the policy.

DEDUCTIBLES

Claims are paid based on the insurance policy. Most insurance policies include a deductible, which is the amount you are responsible for before your coverage begins. Various types of losses may have different deductible amounts.

GLOSSARY:

ADJUSTER - An independent representative of the insurer who seeks to determine the extent of the insurer's liability for loss when a claim is submitted.
DAMAGE – Harm or injury resulting in loss of value or usefulness.
DEDUCTIBLE - Amount of loss that the insured incurs before the insurance can pay.
EXAMINER - The representative of an insurance company assigned to review claims made against insurance companies.
MITIGATE - To make less severe or serious, often with professional help.
POLICY - The written insurance contract including all clauses, riders, endorsements, and attached papers.
SUBLIMIT - The limit of how much can be paid on a specific type of loss.
WEAR & TEAR - The normal, expected deterioration of an insured object (wear and tear is excluded from insurance policy coverage because it is inevitable).

FOR MORE INFORMATION, SUBSCRIBE TO OUR SOLUTIONS NEWSLETTER AT:
www.adventistrisk.org

Adventist Risk Management, Inc.

NORTH AMERICAN DIVISION GENERAL LIABILITY STATEMENT OF LOSS

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: (301) 680-6870 | **FAX:** (301) 680-6878
EMAIL: claims@adventistrisk.org

CONFERENCE:

▷ ABOUT THE INSURED:

CHURCH / SCHOOL / OTHER NAME:

CONTACT PERSON NAME:

TELEPHONE | BUSINESS: RESIDENTIAL: EMAIL ADDRESS:

CHURCH / SCHOOL / OTHER ADDRESS: CITY: STATE: ZIP CODE:

▷ ABOUT THE LOSS: *DATE & TIME OF LOSS*

MONTH	DAY	YEAR	TIME
			AM PM

DESCRIPTION OF ACCIDENT:

▷ ABOUT THE LOCATION OF INCIDENT:

NAME OF OWNER OF PREMISES:

ADDRESS: CITY: STATE: ZIP CODE:

TELEPHONE | BUSINESS: RESIDENTIAL: RELATIONSHIP TO INSURED:

▷ ABOUT THE INJURED PERSON OR DAMAGED PROPERTY:

NAME: DATE OF BIRTH: (MM/DD/YYYY) SOCIAL SECURITY #: ☐ MALE ◯ FEMALE

ADDRESS: CITY: STATE: ZIP CODE:

TELEPHONE | BUSINESS: RESIDENTIAL: EMAIL ADDRESS:

DESCRIPTION INJURY OR DAMAGE: *(EXAMPLE: FRACTURED ARM, SPRAINED BACK, BROKEN WINDOW, ETC.)*

DESCRIBE PROPERTY: *(TYPE, MODEL, ETC.)* ESTIMATED AMOUNT OF REPAIR:

EMPLOYER'S NAME: RELATIONSHIP TO INSURED / ENTITY:

ADDRESS: CITY: STATE: ZIP CODE:

TELEPHONE | BUSINESS: RESIDENTIAL:

▷ WITNESS:

FIRST NAME: M.I. LAST NAME:

TELEPHONE | BUSINESS: RESIDENTIAL:

ADDRESS: CITY: STATE: ZIP CODE:

▷ COMMENTS:

▷ REPORTED BY: TITLE: PHONE#

REPORTED TO: TITLE: DATE (MM/DD/YYYY):

▷ SIGNATURE OF INSURED: DATE (MM/DD/YYYY):

(Form Date: 03/27/2014)

GENERAL LIABILITY

CLAIM INFORMATION
IMMEDIATE AND TIMELY REPORTING IS CRITICAL

DOCUMENTATION NEEDED: ***(TO ACCOMPANY COMPLETED CLAIM FORM)***

- If an attorney is involved, provide name and address.
- Have papers been served? If so, when? Attach a copy.
- Copies of medical bills, if any.

ADDITIONAL DOCUMENTATION NEEDED FOR MEDICAL PROFESSIONAL LIABILITY SITUATIONS:

- Medical Records
- Incident Report
- Any statements by medical personnel.

PROCEDURE:

Please send above information to Adventist Risk Management, Inc. ARM may assign an adjuster in complex situations, it is important for you to cooperate with them. If there are any problems, let us know immediately.

ANY ADDITIONAL INFORMATION MUST BE FORWARDED UPON RECEIPT

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
OFFICE: (301) 680-6870 - FAX: (301) 680-6878
EMAIL: claims@adventistrisk.org

Robert H. Burrow | JD
Managing Claims Counsel
OFFICE: (301) 680-6875 | CELL: (301) 346-9642
EMAIL: **rburrow@adventistrisk.org**

Donna L. Diaz | JD
Claims Counsel
OFFICE: (951) 353-6803 | CELL: (951) 754-3574
EMAIL: **ddiaz@adventistrisk.org**

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Claims Counsel
OFFICE: (301) 680-6927 | CELL: (443) 995-4512
EMAIL: **jdoukmetzian@adventistrisk.org**

J. Victor Elliott | AIC
Claims Counsel
OFFICE: (301) 680-6808 | CELL: (301) 332-2017
EMAIL: **jvelliott@adventistrisk.org**

Geoffrey Hayton | JD
Claims Counsel
OFFICE: (951) 353-6822 | CELL: (909) 894-8235
EMAIL: **ghayton@adventistrisk.org**

Adventist Risk Management, Inc.

NORTH AMERICAN DIVISION PROPERTY STATEMENT OF LOSS

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: 1 (888) 951-4ARM (4276) | **FAX:** (301) 680-6878
EMAIL: claims@adventistrisk.org

FOR YOUR PROTECTION SOME STATE LAWS REQUIRE THAT THE FOLLOWING STATEMENT APPEAR ON THIS FORM:
"IT IS UNLAWFUL TO: (A) PRESENT OR CAUSE TO BE PRESENTED ANY FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS UNDER A CONTRACT OF INSURANCE AND/OR (B) PREPARE, MAKE, OR SUBSCRIBE ANY WRITING WITH INTENT TO PRESENT OR USE THE SAME, OR TO ALLOW IT TO BE PRESENTED OR USED IN SUPPORT OF ANY SUCH CLAIM. EVERY PERSON WHO VIOLATES ANY PROVISION OF THIS SECTION IS PUNISHABLE BY IMPRISONMENT IN THE STATE PRISON NOT EXCEEDING THREE YEARS, OR BY FINE NOT EXCEEDING ONE THOUSAND DOLLARS, OR BY BOTH."

▷ POLICY:

CONFERENCE:						
NAME OF ENTITY:						
DAMAGED PROPERTY - ADDRESS:			CITY:		STATE:	ZIP CODE:
POINT OF CONTACT - FIRST NAME:		M.I.	LAST NAME:			
TELEPHONE | BUSINESS:	RESIDENTIAL:		EMAIL ADDRESS:			

▷ DESCRIPTION OF WHEN AND HOW LOSS OCCURRED: *IF EXACT DATE IS NOT KNOWN, GIVE DATE OF DISCOVERY*

MONTH	DAY	YEAR	TIME		
				AM	PM

DESCRIPTION OF ACCIDENT/NATURE OF ACTIVITY *(USE ADDITIONAL SHEET IF NECESSARY)*

▷ DESCRIPTION OF PROPERTY DAMAGED OR STOLEN: *(SUPPORT WITH WRITTEN **VENDOR ESTIMATES** AND **PHOTOS**. USE ADDITIONAL SHEETS IF NECESSARY)*

MAKE, MODEL, SERIAL NUMBER	APPROXIMATE AGE	REPLACEMENT COST

▷ ESTIMATE OF LOSS:

BUILDING:	$	STOLEN GOODS:	$	TOTAL ESTIMATES:	$
CONTENTS:	$	STOLEN MONEY:	$	LESS DEDUCTIBLE:	$
TEMPORARY REPAIRS:	$	GLASS:	$	NET ESTIMATE:	$

▷ ALL CRIME LOSSES MUST BE REPORTED TO POLICE:

DATE REPORTED TO POLICE *(MM/DD/YYYY)*:	POLICE REPORT NUMBER:		
INVESTIGATING ORGANIZATION:		PHONE NUMBER:	
ADDRESS:	CITY:	STATE:	ZIP CODE:

▷ SIGNATURE OF AUTHORIZED ENTITY REPRESENTATIVE: TITLE: DATE OF SIGNING (MM/DD/YYYY):

▷ SIGNATURE OF AUTHORIZED INSURED REPRESENTATIVE: TITLE: DATE OF SIGNING (MM/DD/YYYY):

FAILURE TO PROMPTLY REPORT LOSS OR DAMAGE IS A CONTRACT VIOLATION AND MAY VOID COVERAGE. SUPPLY AS MUCH INFORMATION AS POSSIBLE TO AVOID DELAY.

DENOMINATIONAL PROPERTIES

IF REPORTING A CATASTROPHIC LOSS, (HURRICANE, FIRE, FLOODS, EARTHQUAKE, VOLCANO, ETC.)
PLEASE REPORT IMMEDIATELY TO THE ADVENTIST RISK MANAGEMENT CLAIMS DEPARTMENT
FOR FURTHER INSTRUCTIONS BEFORE COMPLETING THE FOLLOWING STEPS.

Adventist Risk Management, Inc.
12501 Old Columbia Pike
Silver Spring, MD 20904
OFFICE: 1 (888) 951-4ARM (4276) - FAX: (301) 680-6878
EMAIL: claims@adventistrisk.org

CLAIMS INFORMATION

SEND LOSS NOTICE IMMEDIATELY - THE FOLLOWING DOCUMENTATION IS NEEDED TO COMPLETE THE CLAIM PROCESS AS SOON AS IT IS AVAILABLE.

BUILDING: (ITEMIZED REPLACEMENT COST)
- Itemized written estimates or invoices for material and labor by a contractor.
- If labor is done by members, number of man-hours times the amount that would be paid per hour.

CONTENTS: (REPLACEMENT COST)
- Must have written replacement estimates or bills for items of like kind and quality, or repair estimates if items are repairable.

MONEY & SECURITIES:
- Furnish accounting records to substantiate loss. If unavailable, give explanation of how amount was determined.

INLAND MARINE: (SCHEDULED DECLARED VALUE)
- Give name of entity under which the item is scheduled and the serial number as listed on your statement of values.

BURGLARY & THEFT:
- Police report. If you cannot get report, give name of Police Station reported to and the report number.

STORM & FIRE LOSSES:
- Pictures and newspaper clippings.
- Fire Marshall's Report of Fire.

CHECK LIST

√ DATE OF LOSS
√ EXACT LOCATION AND COMPLETE STREET ADDRESS
√ EXACTLY WHAT IS BEING CLAIMED (MATERIAL, LABOR, CASH, CONTENTS, ETC.)
√ SIGNATURE OF AUTHORIZED REPRESENTATIVE OF ENTITY

FAILURE TO PROMPTLY REPORT LOSS OR DAMAGE IS A CONTRACT VIOLATION AND MAY VOID COVERAGE. SUPPLY AS MUCH INFORMATION AS POSSIBLE TO AVOID DELAY.

Adventist Risk Management, Inc.

AUTOMOBILE LOSS NOTICE

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: 1 (888) 951-4ARM (4276) | **FAX:** (301) 680-6878
EMAIL: claims@adventistrisk.org

▷ INSURED:

CHURCH, SCHOOL OR OTHER:	CONTACT NAME:	CONTACT - HOME PHONE:
CONFERENCE/MISSION:	CONTACT EMAIL:	CONTACT - WORK PHONE:

▷ LOSS INFORMATION:

MONTH	DAY	YEAR	TIME
			AM PM

LOCATION OF ACCIDENT - ADDRESS: | CITY: | STATE: | ZIP CODE:

DATE REPORTED TO POLICE *(MM/DD/YYYY)*: | POLICE REPORT NUMBER: | VIOLATIONS / CITATIONS:

DESCRIPTION OF ACCIDENT/NATURE OF ACTIVITY *(USE ADDITIONAL SHEET IF NECESSARY)*

▷ INSURED VEHICLE:

YEAR, MAKE, MODEL: | V.I.N. (LAST 5 DIGITS OF ID#):

OWNER - FIRST NAME: | M.I. | LAST NAME: | EMAIL ADDRESS:

ADDRESS: | CITY: | STATE: | ZIP CODE:

DRIVER - FIRST NAME: | M.I. | LAST NAME: | EMAIL ADDRESS:

ADDRESS: | CITY: | STATE: | ZIP CODE:

RELATIONSHIP TO INSURED: | DATE OF BIRTH: | PURPOSE OF VEHICLE USE: | WAS DRIVER INJURED? ☐ YES ◯ NO

DESCRIBE DAMAGE: | USED WITH PERMISSION? ☐ YES ◯ NO

ESTIMATE AMOUNT: | WHERE CAN VEHICLE BE SEEN? - ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ DAMAGED PROPERTY: *FOR VEHICLE INFORMATION OTHER THAN ABOVE*

DESCRIBE PROPERTY (IF AUTO: YEAR, MAKE, MODEL, PLATE NO):

INSURANCE COMPANY OR AGENCY NAME & POLICY # (IF ANY):

OWNER - FIRST NAME: | M.I. | LAST NAME: | HOME PHONE: | WORK PHONE:

ADDRESS: | CITY: | STATE: | ZIP CODE:

DRIVER - FIRST NAME: | M.I. | LAST NAME: | HOME PHONE: | WORK PHONE:

ADDRESS: | CITY: | STATE: | ZIP CODE:

DESCRIBE DAMAGE: | ESTIMATE AMOUNT:

WHERE CAN VEHICLE BE SEEN? - ADDRESS: | CITY: | STATE: | ZIP CODE: | WAS DRIVER INJURED? ☐ YES ◯ NO

▷ PASSENGERS: *USE ADDITIONAL SHEETS IF NECESSARY*

NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? ☐ YES ◯ NO

ADDRESS: | CITY: | STATE: | ZIP CODE:

NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? ☐ YES ◯ NO

ADDRESS: | CITY: | STATE: | ZIP CODE:

NAME: | M.I. | LAST NAME: | PHONE NUMBER: | INJURED? ☐ YES ◯ NO

ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ WITNESSES: *USE ADDITIONAL SHEETS IF NECESSARY*

NAME: | M.I. | LAST NAME: | PHONE NUMBER:

ADDRESS: | CITY: | STATE: | ZIP CODE:

NAME: | M.I. | LAST NAME: | PHONE NUMBER:

ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ INCIDENT REPORTED BY: | DATE (MM/DD/YYYY):

▷ LOSS NOTICE COMPLETED BY: | DATE (MM/DD/YYYY):

▷ SIGNATURE OF INSURED'S AUTHORIZED REPRESENTATIVE: | DATE OF SIGNING (MM/DD/YYYY):

Adventist Risk Management, Inc.

NORTH AMERICAN DIVISION MEDICAL PAYMENTS STATEMENT OF LOSS

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: (301) 680-6870 | **FAX:** (301) 680-6878
EMAIL: claims@adventistrisk.org

TO BE COMPLETED BY CHURCH ORGANIZATION

CONFERENCE:

CHURCH NAME:

CHURCH ADDRESS: | CITY: | STATE: | ZIP CODE:

CHURCH CONTACT PERSON :

TELEPHONE | BUSINESS: | RESIDENTIAL: | EMAIL ADDRESS:

▷ ABOUT THE INJURED PERSON:

FIRST NAME: | M.I. | LAST NAME: | DATE OF BIRTH: (MM/DD/YYYY) | SOCIAL SECURITY #: | ☐ MALE ◯ FEMALE

ADDRESS: | CITY: | STATE: | ZIP CODE:

TELEPHONE | BUSINESS: | RESIDENTIAL: | EMAIL ADDRESS:

NAME OF PARENT / GUARDIAN*: | DATE OF ACCIDENT: (MM/DD/YYYY) | TIME OF ACCIDENT: | AM | PM

DESCRIBE THE INJURY:

HOW DID ACCIDENT HAPPEN?:

LOCATION OF ACCIDENT - ADDRESS: | CITY: | STATE: | ZIP CODE:

DATE ACCIDENT REPORTED: (MM/DD/YYYY) | TYPE OF ACTIVITY: | TIME OF ACTIVITY - COMMENCED: | DISMISSED

DOES THE INJURED PERSON HAVE OTHER INSURANCE? ☐ YES ◯ NO

OTHER INSURANCE NAME:

OTHER INSURANCE - ADDRESS: | CITY: | STATE: | ZIP CODE:

▷ DID THE ACCIDENT OCCUR DURING:

ACTIVITY - LEADER:

TITLE:

CHURCH FUNTION:	☐ YES ◯ NO	CAMP:	☐ YES ◯ NO	ON ACTIVITY PREMISES:	☐ YES ◯ NO
VACATION BIBLE SCHOOL:	☐ YES ◯ NO	OTHER:	☐ YES ◯ NO	WHILE TRAVELING TO OR FROM AN ACTIVITY IN AN AUTHORIZED AUTOMOBILE:	☐ YES ◯ NO
PATHFINDER:	☐ ◯ NO	WHILE SUPERVISED:	☐ YES ◯ NO	IN THE COURSE OF YOUR EMPLOYMENT:	☐ YES ◯ NO

DURING SPOSORED ACTIVITY: ☐ YES ◯ NO

DURING PROGRAMMED HOURS: ☐ YES ◯ NO

▷ WITNESSES:

FIRST NAME: | TELEPHONE | BUSINESS: | RESIDENTIAL:

ADDRESS: | CITY: | STATE: | ZIP CODE:

FIRST NAME: | TELEPHONE | BUSINESS: | RESIDENTIAL:

ADDRESS: | CITY: | STATE: | ZIP CODE:

FIRST NAME: | TELEPHONE | BUSINESS: | RESIDENTIAL:

ADDRESS: | CITY: | STATE: | ZIP CODE:

I hereby certify that the statements made above are correct to the best of my knowledge and believe that the above claimant was covered hereunder at the time of the accident/sickness.

▷ SIGNATURE OF SUPERVISORY OFFICIAL: | DATE (MM/DD/YYYY):

ATTACH PHYSICIAN'S STATEMENT AND/OR ITEMIZED BILLING TO THIS FORM

Adventist Risk Management, Inc.

VOLUNTEER LABOR

GBG ACCIDENT MEDICAL EXPENSE

Adventist Risk Management, Inc.
12501 Old Columbia Pike - Silver Spring, MD 20904
PHONE : 1-888-951-4ARM (4276) | **FAX :** (301) 680-6878
E-MAIL: claims@adventistrisk.org

HOW TO FILE A CLAIM

1. Complete all items on the attached claim form.

2. Attach the following documents:
   - Letter from church pastor, head elder or conference employee verifying accident occurred while volunteer was participating in a scheduled, sponsored and supervised volunteer activity, or traveling to or from such activity.
   - Copies of fully itemized medical bills. Itemized bills must show the patient's name, date of service, the type of service rendered, the diagnosis or nature of condition being treated and the provider's name and address.
   - Copies of the Explanation of Benefits from your primary insurance carrier

3. Send the completed and signed claim form and all required documents to:

Adventist Risk Management, Inc.
12501 Old Columbia Pike Silver Spring, MD 20904
Email:claims@adventistrisk.org
Phone: 1 (888) 951-4ARM (4276)
Fax: (301) 680-6878

4. Retain a copy for your records.

This insurance plan is excess insurance and is designed to provide maximum benefits at minimum cost and is secondary to all other insurance you may have. Please submit all expenses to your primary insurance first. Once that claim has been processed, please include their Explanation of Benefits when submitting your claim for benefits under this policy. Attention Medicare and Medicaid Enrollees: This insurance is primary to your Medicare or Medicaid coverage. If you wish payment to be made to you, you must provide proof of payment from the provider.

YOU WILL BE CONTACTED BY A CLAIM ADJUSTER IF ADDITIONAL INFORMATION OR DOCUMENTATION IS REQUIRED.

Accident Medical Expense

Insured's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name_____ **Social Security #**_____

Insured's Address_____ **Phone No. (H)**_____

_____ **Phone No. (W)**_____

Email address: _____ **Phone No. (C)** _____

Policy Number (Required)_____ **Insured's Date of Birth** _____/_____/_____

Are you eligible for or enrolled in Medicare? _____ **Are you enrolled in Medicaid?** _____

CLAIM INFORMATION

Date of accident _____/_____/_____ **Time and place accident occurred**_____

Please describe in detail the circumstances of accident (attach separate sheet if needed): _____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Please describe the nature of Insured's injuries:_____

Did police or other authorities investigate the accident? ____ **If yes, please provide name, address and telephone number of all investigating officers and agencies:** _____

Please list the names and addresses of all treating/consulting physicians or other healthcare providers:

Name	Street Address	City	State	Zip	Phone

_____

_____

If hospitalized, please provide name and address of hospital(s) where treatment was received:

_____

Do you have any other insurance that may provide coverage for this accident or loss? _____ **If yes, please identify name, address, and policy number of all other insurance:** _____

_____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby authorize any hospital, physician, employer, or other person who has attended or examined the Insured to disclose when requested to do so, any information to NAHGA Claim Services with respect to any injury, policy coverage, medical history, consultations, prescriptions or treatment as well as providing copies of all hospital and medical records and itemized bills. I know I have a right to receive a copy of this authorization upon request and agree that a photographic or facsimile copy of this authorization is as valid as the original. I swear that the above information is true and correct to the best of my knowledge and understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information or who willfully conceals material information may be subject to prosecution for insurance fraud.

Signed (Insured or authorized person) _____ **Date** ____/____/____

I authorize payment of medical benefits directly to the provider(s) for services rendered in connection with this claim.

Signed (Insured or authorized person)_____ **Date** ____/_____/___

AUTHORIZATION TO RELEASE INFORMATION

I authorize Chubb & Son, a division of Federal Insurance Company ("Chubb") and NAHGA to release certain information regarding my claim, including my name, address and medical information to Adventist Risk Management ("ARM"), Global Benefits Group ("GBG") and its agents to facilitate the administration of the claim and of the policy. I understand that any information I provide to ARM, GBG or its agents is governed by the privacy policy and procedures of the respective organizations and that these organization are not Chubb service providers and Chubb is not responsible for their actions. This authorization shall be valid for 24 months and may be revoked at any time subject to the rights of the individual who acted in reliance on the authorization prior to the notice of the revocation. To revoke this authorization, contact your client representative.

Signed (Insured or authorized person) _____ **Date** _____/_____/_____

Adventist Risk Management, Inc.

CERTIFICATE OF INSURANCE REQUEST

12501 Old Columbia Pike - Silver Spring, MD 20904
OFFICE: 1(888) 951-4276 - **FAX:** 1(866) 460-8767

RUSH ☐ **YES** ◯ **NO**

▷ **ORGANIZATION INSURED:** SOUTHEASTERN CALIFORNIA CONFERENCE

POLICY #: GL201975 **LIMIT:** 1,000,000.00

▷ **TYPE OF INSURANCE:** ☐ GENERAL LIABILITY ☐ PROPERTY ☐ HOSPITAL PROPERTY ☐ AUTOMOBILE ☐ EXCESS LIABILITY ☐ WORKERS COMPENSATION
SELECT YOUR OPTION(S)

▷ **CERTIFICATE HOLDER:**

ORGANIZATION:

ADDRESS: CITY: STATE: ZIP CODE:

CONTACT NAME: PHONE NUMBER:

▷ **EVENT LOCATION:** *(IF DIFFERENT FROM CERTIFICATE HOLDER)*

ADDRESS: CITY: STATE: ZIP CODE:

▷ **ACTIVITY REQUIRING CERTIFICATE:**

BEGINNING DATE (MM/DD/YYYY):

ENDING DATE (MM/DD/YYYY):

ADDITIONAL INSURED: ☐ YES ◯ NO

SPECIFIC WORDING REQUIRED:

SPONSORED BY:

▷ **NEEDED FOR PROPERTY / EQUIPMENT**

VALUE: SERIAL#:

MODEL#: LOAN #:

PLEASE EMAIL CERTIFICATE OF INSURANCE TO: *USE A SEMICOLON TO SEPARATE E-MAIL ADDRESSES IN CASE YOU NEED TO SEND A COPY OF THE* **CERTIFICATE OF INSURANCE** *TO MULTIPLE RECIPIENTES*

PLEASE NOTE: CERTIFICATES WILL NO LONGER BE ISSUED BY FAX OR MAIL. PLEASE PROVIDE E-MAIL ADDRESSES OF ANYONE NEEDING TO RECEIVE A COPY OF THE CERTIFICATE.

COMMENTS:

▷ **REQUESTED BY:** LORI LORBEER **DATE** (MM/DD/YYYY):

ENTER THE NAME OF YOUR CUSTOMER SERVICE REPRESENTATIVE: YESIKA VENTURA