Full Time Employee Hire and Benefit Enrollment Information

The following forms must be completed and returned to the Human Resources Office, J101, in order to be placed on payroll. Questions can be directed to Human Resources staff at (989)686-9107.

Employee Name: _____ Date of Hire: _____

Home Phone Number: _____

Address: _____

ETHNICITY: ***(please circle one)***
(**1**-Not Hispanic or Latino) (**2**-Hispanic or Latino)

GENDER: ***(please circle one)***
(**1**-Female) (**2**- Male)

RACE: ***(please circle one or more)*****:**
(African American) (American Indian or Alaskan Native) **(**Asian) (Caucasian)
(Native Hawaiian or Other Pacific Island)

All new employees are required to review each of the items listed below

- **Delta College's Vision and Mission Statement**
- **Electronic Resources** – For access to Delta's electronic resources please go through the signup process. You must have completed and returned your payroll paperwork prior to sign up.
- **Payroll dates** - employees are paid biweekly on Fridays for the previous 2 weeks (7 days in arrears)
- **Category A employee** ☐ Yes ☐ NO
  - If Category A, employee must complete the attached Hepatitis B Vaccination Form. Form and Exposure Manual notes Category A positions.
  - Exposure Manual available for review on Inside Delta.
- **Review of Procedure Manual and appropriate Handbooks and/or Collective Bargaining Agreements within the Policies and Disclosures Tab on Inside Delta**
- **Drug and Alcohol Prevention Program (DAAPP)**
- **Safety Services**
  ☐ N-O-R-A: Need Officer Right Away ☐ Emergency Text Notification/Nixle ☐ Adverse Weather
  ☐ Tobacco Free Campus ☐ Delta College Emergency Procedures

By signing this form, you are verifying that you have completed the payroll forms and agree to review all of the items listed above within the first 30 days of employment.

Employee Signature: _____ Date: _____

Delta College
Emergency Information

Employee Name: _____

Position: _____

_____Faculty
_____Staff

_____Full-time
_____Part-time

IN CASE OF AN EMERGENCY NOTIFY:

First choice:	
Name	
Address	
Day Phone	
Evening Phone	
Relationship	

Second choice:	
Name	
Address	
Day Phone	
Evening Phone	
Relationship	

1. Do you have any health and/or medication information you want the College to know in the event of emergency situations:

2. Additional Comments:

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

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

OMB No. 1545-0074

2024

Step 1: Enter Personal Information

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

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

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

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

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

Step 3: Claim Dependent and Other Credits

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

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

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

Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . . **3** $

Step 4 (optional): Other Adjustments

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

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

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

Step 5: Sign Here

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

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

Employers Only

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

General Instructions

Section references are to the Internal Revenue Code.

Future Developments

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

Purpose of Form

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

Exemption from withholding. You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

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

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

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

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

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

Specific Instructions

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

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

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

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

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

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

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

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

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

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

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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

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

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

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

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

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

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

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

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

1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income . . . . . **1** $

2 Enter:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 if you're single or married filing separately

. . . . . **2** $

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

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

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

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

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

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

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

Married Filing Jointly or Qualifying Surviving Spouse

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$0	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	$0 - 9,999	$10,000 - 19,999	$20,000 - 29,999	$30,000 - 39,999	$40,000 - 49,999	$50,000 - 59,999	$60,000 - 69,999	$70,000 - 79,999	$80,000 - 89,999	$90,000 - 99,999	$100,000 - 109,999	$110,000 - 120,000
$0 - 9,999	$0	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

MI-W4

(Rev. 12-20)

EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE
STATE OF MICHIGAN - DEPARTMENT OF TREASURY

This certificate is for Michigan income tax withholding purposes only. ***Read instructions on page 2 before completing this form.***

Issued under P.A. 281 of 1967.

▶ 1. Full Social Security Number	▶ 2. Date of Birth
▶ 3. Name (First, Middle Initial, Last)	4. Driver's License Number or State ID
Home Address (No., Street, P.O. Box or Rural Route)	▶ 5. Are you a new employee? ☐ Yes If Yes, enter date of hire..... (mm/dd/yyyy) ☐ No
City or Town / State / ZIP Code	

6. Enter the number of personal and dependent exemptions (see instructions) ..... ▶ 6.

7. Additional amount you want deducted from each pay (if employer agrees) .....7. $ .00

8. I claim exemption from withholding because (see instructions):

a. ☐ A Michigan income tax liability is not expected this year.

b. ☐ Wages are exempt from withholding. Explain: _____

c. ☐ Permanent home (domicile) is located in the following Renaissance Zone: _____

EMPLOYEE: If you fail or refuse to file this form, your employer must withhold Michigan income tax from your wages without allowance for any exemptions. Keep a copy of this form for your records. See additional instructions on page 2.

Under penalty of perjury, I certify that the number of withholding exemptions claimed on this certificate does not exceed the number I am allowed to claim. If claiming exemption from withholding, I certify that I do not anticipate a Michigan income tax liability this year.

9. Employee's Signature	▶ Date

EMPLOYER: Complete the below section.

10. Employer's Name	▶ 11. Federal Employer Identification Number		
Address (No., Street, P.O. Box or Rural Route)	City or Town	State	ZIP Code
Name of Contact Person	Contact Phone Number		

INSTRUCTIONS TO EMPLOYER: Keep a copy of this certificate with your records. All new hires must be reported to the State of Michigan. See **www.mi-newhire.com** for information.

In addition, a copy of this form must be sent to the Michigan Department of Treasury if the employee claims 10 or more exemptions or claims they are exempt from withholding. Send a copy to:

Michigan Department of Treasury
Tax Technical Section
P.O. Box 30477
Lansing, MI 48909

INSTRUCTIONS TO *EMPLOYEE'S MICHIGAN WITHHOLDING EXEMPTION CERTIFICATE* (Form MI-W4)

You must submit a Michigan withholding exemption certificate (form MI-W4) to your employer on or before the date that employment begins. If you fail or refuse to submit this certificate, your employer must withhold tax from your compensation without allowance for any exemptions. Your employer is required to notify the Michigan Department of Treasury if you have claimed 10 or more personal or dependency exemptions or claimed that you are exempt from withholding.

You MUST provide a new MI-W4 to your employer within 10 days if your residency status changes or if your exemptions decrease because: a) your spouse, for whom you have been claiming an exemption, is divorced or legally separated from you or claims his/her own exemption(s) on a separate certificate, or b) a dependent no longer qualifies under the Internal Revenue Code.

Line 5: If you check "Yes," enter your date of hire.

Line 6: Personal and dependency exemptions. The number of exemptions claimed here may not exceed the number of exemptions you are entitled to claim on a *Michigan Individual Income Tax Return* (Form MI-1040). Dependents include qualifying children and qualifying relatives under the Internal Revenue Code, even if your AGI exceeds the limits to claim federal tax credits for them.

Do not claim the same exemptions more than once or tax will be under-withheld. Specifically, **do not claim:**

- Your personal exemption if someone else will claim you as their dependent.
- Your personal exemption with more than one employer at a time.
- Your spouse's personal exemption if they claim it with their employer.
- Your dependency exemptions if someone else (for example, your spouse) is claiming them with their employer.

Line 7: You may designate additional withholding if you expect to owe more than the amount withheld.

Line 8a: You may claim exemption from Michigan income tax withholding if all of the following conditions are met:

i) Your employment is intermittent, temporary, or less than full time;

ii) Your personal and dependency exemptions exceed your annual taxable compensation;

iii) You claimed exemption from federal withholding; and

iv) You did not incur a Michigan income tax liability for the previous year.

Line 8b: Reasons wages might be exempt from withholding include:

- You are a nonresident spouse of military personnel stationed in Michigan.
- You are a resident of one of the following reciprocal states while working in Michigan: Illinois, Indiana, Kentucky, Minnesota, Ohio, or Wisconsin.
- You are an enrolled member of a federally-recognized tribe that does not have a tax agreement with the state of Michigan, you reside within that tribe's Indian Country (as defined in 18 USC 1151), and compensation from this job will be earned within that Indian Country.

Line 8c: For questions about Renaissance Zones, contact your local assessor's office.

City of Saginaw Withholding Information

In accordance with the City of Saginaw Income Tax Ordinance, all Delta College employees who are residents of the City of Saginaw or work within the City of Saginaw are required to have city income tax withholdings from their payroll and must complete a Form SW-4 Withholding Certificate.

Delta College is located within University Center, Delta College is not located within the City of Saginaw. Except for the following site locations, which are within the City of Saginaw:

- The Downtown Saginaw Center
- Saginaw MiWorks!
- St. Mary's of Michigan clinical site
- Covenant Healthcare clinical sites

For detailed requirements of the City of Saginaw Income Tax Ordinance, please review the City of Saginaw Withholding Tax Guide.

Please complete the following Form SW-4 Withholding Certificate, SW-4, if either of below apply:

- **You work within the City of Saginaw** (see above listing of Delta College site locations within the City of Saginaw)
    - If you split your time at a City of Saginaw location and non City of Saginaw location, there is a section on the form where you can note you work X% amount of time in the City of Saginaw and X% amount of time at another Delta College location
- **You reside within the City of Saginaw**

OR

_____**Check here if you do not live nor work in the City of Saginaw, and do not want City of Saginaw taxes withheld** (If you check this, you do not need to compete the following SW-4 form)

Employee Name: _____

Date: _____

Form SW-4 Instructions - revised 1/05/10

Purpose: Complete form SW-4 so your employer can withhold the correct amount of city income taxes from your pay.

Dependents: To qualify as your dependent (line 4 below), a person

(a) Must receive more than one-half of his or her support from you for the year, and
(b) Must have less than $750.00 gross income during the year (except your child who is a student or who is under 19 years of age, and
(c) Must not be claimed as an exemption by such person's husband or wife, and
(d) Must be a citizen or resident of the United States, and
(e) Must have your home as his/her principal residence and be a member of your household for the entire year, or Must be related to you as follows: Your son or daughter, grandchild, step-son/daughter, son/daughter-in-law, father, mother, grandparent, step-father/mother, father/mother-in-law, brother, sister, stepbrother/sister, half brother/sister, brother/sister-in-law, uncle, aunt, nephew, or niece **(but only if related by blood)**.

Changes in exemptions: You ***must*** file a new certificate within 10 days if the number of exemptions previously claimed by you ***decreases*** for any of the following reasons:

(a) Your wife/husband for whom you have been claiming exemption is divorced or legally separated, or claims her/his own exemption on a separate certificate.
(b) The support of a dependent for whom you claimed exemption is taken over by someone else.
(c) You find that a dependent for whom you claimed exemption will receive $750.00 or more income of his/her own during the year (except your child who is a student and who is under 19 years of age).

Other Decreases: Such as the death of a wife, husband, or a dependent, do not affect your withholding until the next year, but require the filing of a new certificate by December 1 of the year in which they occur.

Change of Residence: You ***must*** file a new certificate within 10 days after you change your residence from or to a taxing city.

Employee: File this form with your employer. Otherwise your employer must withhold City of Saginaw income tax from your earnings without exemptions.

Employer: Keep this certificate with your record. If the information submitted by the employee is not believed to be true, correct and complete the ***City of Saginaw*** must be advised.

FORM SW-4	**EMPLOYEE'S WITHHOLDING CERTIFICATE FOR CITY OF SAGINAW INCOME TAX**	
☐ **City Resident or** ☐ **Non-City Resident**		Your Social Security Number:
Full Name: (First, Middle and Last Name)	Home Address: (Number & Street)	
City:	State:	Zip Code:
Main place of employment: Print name of each city where you work for this employer and circle closest % of total earnings in each. This is for withholding purposes only.	City:	Under 25%☐ 40%☐ 60%☐ 80%☐ 100%☐
	City:	Under 25%☐ 40%☐ 60%☐ 80%☐ 100%☐
1. Exemptions for yourself: ☐ Yourself ☐ age 65 or over ☐ Blind	**2. Exemptions for your spouse:** ☐ Yourself ☐ age 65 or over ☐ Blind	**3. Enter Total number of boxes checked in 1& 2**:
4. Other Exemptions: _____ Number of exemptions for your children _____ Number of exemptions for your other dependents		**5. Enter total number of Other Exemptions in box 4 below:**
6. Add the number of exemptions which you have claimed in box 3 & 5 and write the total below:	**7. Write the additional amounts you want withheld from each paycheck, if any:**	
Employer's Name and Address:		
I certify that the information submitted on this certificate is true, correct and complete to the best of my knowledge and belief. **SIGNATURE:** **DATE:**		

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Delta College	1961 Delta Rd, University Center MI 48710

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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 an individual temporarily authorized to work for a specific employer because of his or her status or parole: **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 individual's status or parole 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 For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

DELTA COLLEGE BENEFITS ENROLLMENT FORM
PLAN YEAR: 2024

Section A - Employee Information

Employee Name:		Social Security No:	
Address:		City/State/Zip:	
Email Address:		Employee ID#:	
Phone:	Sex:	Date of Hire:	Date of Birth:

Section B – Select Action (circle one)

Effective Date of Qualifying Event:

Open Enrollment		New Hire/Full-time Position	Resignation/Retirement
Birth of Child	Marriage	Divorce	Other:

Qualifying events must be communicated within 30 days to Human Resources. Failure to notify Human Resources within 30 days may cause the employee to be liable for insurance claims and college paid health, vision and dental premiums. Documentation is required for qualifying events to be processed. (Additions - marriage licenses and birth certificates. Removal - divorce decree)

Section C – Benefit Elections

Health/Vision/Dental Insurance (circle election below)

1) DECLINE health insurance but receive College paid vision and dental insurance

Vision / Dental	Single	2 Person	Family

2) College paid dental insurance

	Single	2 Person	Family

3) PPO Plan and College paid vision insurance

	Single	2 Person	Family
20% cost share of premium	$133 / month	$319 / month	$399 / month

4) High Deductible Health Plan with Health Savings Account and College paid vision insurance

	Single	2 Person	Family
20% cost share of premium	$108 / month	$259 / month	$324 / month
HSA Additional Employee Contribution Single ($4,150 max) 2P/Family ($8,300 max)	$ / pay	$ / pay	$ / pay

Flexible Spending Accounts

Cannot participate if you & your spouse have an HSA.	Health Care maximum $3,200 annually	$	Annual Amount
	Dependent Care maximum $5,000 annually	$	Annual Amount

Section D – Dependent Information

Name (First, MI, Last)	Social Security #	Birth Date	M/F	Check One Add	Remove
Spouse					
Dep. 1					
Dep. 2					
Dep. 3					
Dep. 4					

COBRA NOTIFICATION ADDRESS: _____

Complete only if you are discontinuing coverage for a covered member

Section E - Authorization

I acknowledge that:

- I have reviewed Delta College's benefit plan documents for which I am enrolling.
- By signing this form, I make a binding election concerning my benefits for the plan year of January 1 – December 31, 2024.
- I understand that I will not be able to change my elections unless I have a qualifying event. (marriage, divorce, death, birth or adoption of a child, termination of employment of a spouse, or other such qualifying events allowed by the plans)
- I authorize Delta College to reduce my annual salary in accordance with my elections.
- Eligible deductions will be taken on a pre-tax basis and my social security benefits may be reduced.
- Delta College may reduce or cancel my compensation reduction or otherwise modify this agreement in the event that it is advisable in order to satisfy certain provisions of the IRS.
- I will be offered the opportunity to change my benefit elections for the following plan year during open enrollment.
- If I do not complete and return a new election form during open enrollment, these elections will remain in place for future plan years except for Flexible Spending.
- Any Flex Spending payroll contribution not collected must be paid to Delta College within 30 days of the payroll date it was due. Failure to pay within this timeframe will terminate participation in the Flex Spending Plan for the remainder of the year.
- The Flex Spending debit card is to be used exclusively for qualified expenses incurred during the Plan Year. If used for an unqualified expense or if substantiation is not provided, I authorize Delta College to take an after-tax deduction from my paycheck to cover the expense.
- I understand that I could forfeit Flex Spending Plan contributions if I fail to incur eligible expenses during the Plan Year or fail to submit payment requests with in the timeframe specified by the Plan Document.
- Employees on a sick or FMLA leave continue to be responsible for paying their share of premiums for benefit plans. If the employee fails to pay their share of the premiums, the coverage will be terminated with prior notice.
- The primary insured/HSA account holder cannot have dual coverage. Each spouse must open a separate HSA.
- I affirm that the information provided is correct. I understand that if I submit false information, I may be held financially responsible for all claims filed and be required to reimburse the College for any payments made on behalf of or for the benefit of an ineligible dependent.

Employee Signature: _____ Date: _____

HUMAN RESOURCES OFFICE USE ONLY

Transfer		**Benefit**	**Benefit Effective/Separation Date**	**Colleague Processed**	
From:		PPO / HDHP-HSA			COBRA
To:		Dental			PREL / PBEN
		Vision			1095C
		Flexible Spending	Notify Navia / Payroll		

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT FORM FOR DELTA COLLEGE

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer	Group Customer #	Report #	Sub Division	Branch
Delta College	119873	119873		

Employer's Street Address	City	State	Zip Code	Employee's Work Location
1961 Delta Road	University Center	MI	48710	

Date of Hire (Mo./Day/Yr.)	Employee's Basic Annual Earnings (BAE) $	Employee's Occupation	Coverage Effective Date (Mo./Day/Yr.)

Work Status: ☐ New Hire ☐ Active ☐ Retired ☐ Disabled ☐ Rehire ☐ On Layoff/Leave of Absence

Hours Worked Per Week: ☐ Hourly Paid ☐ Salaried ☐ Full-Time ☐ Part-Time

Reason for Enrollment: ☐ New Coverage ☐ New Hire/First Time Eligible ☐ Late Enrollee (Statement of Health Required)
☐ Change in Coverage Amount Requested ☐ Change in Enrollment Other Than Coverage Amount
☐ Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____

SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security #	Date of Birth (Mo./Day/Yr.)	☐ Male ☐ Female

Address Street City State Zip Code

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

E-mail Address

Phone No. (include area code)

COVERAGE REQUEST DATA:

I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits for which I am or may become eligible, requested below.

I request the following coverage:

Employee Coverage

☒ Basic Life (Employer Paid) ☒ Basic Accidental Death & Dismemberment (AD&D) (Employer Paid)

☐ Supplemental/Optional Life

You may elect a multiple of $10,000 up to a maximum of $500,000.
Note: Amounts exceeding $80,000 require a Statement of Health form.
Amount Requested: $_____

☐ Long term Disability (LTD)

Dependent Spouse Coverage

☐ Dependent Spouse Life*

You may elect a multiple of $5,000 up to a maximum of $250,000.
Note: Amounts exceeding the lesser of 1x Basic Annual Earnings or $50,000 require a Statement of Health form.
Amount Requested: $_____

Dependent Child Coverage

☐ Dependent Child Life*

☐ $2,000 ☐ $4,000 ☐ $6,000 ☐ $8,000 ☐ $10,000

*Amounts will be subject to state limits, if applicable.

If applying for Dependent coverage (Spouse and Child), complete section below:

Number of dependents (including spouse) ____

Name of Spouse (Last, First, MI)	Date of Birth	Sex (M/F)	
Name(s) of Child(ren) (Last, First, MI)	**Date of Birth**	**Sex (M/F)**	**Is child a full-time student?**
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes

GEF02-1
ADM

Please Retain A Copy Of The Fully-Completed Form For Your Records And Return The Original To Your Employer

(Continued on Following Page)

Have you smoked cigarettes, pipes or cigars, used snuff or chewed tobacco within one year from the date of this enrollment form?	Employee ☐ Yes ☐ No		
Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?	Employee ☐ Yes ☐ No	Spouse ☐ Yes ☐ No	Child(ren) ☐ Yes ☐ No

If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."

Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

GEF02-1
ADM

DECLARATION SECTION

Each person signing below declares that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee declares that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For the Accelerated Benefits Option

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I understand that if life or disability coverage is not elected, or if the maximum coverage is not elected, evidence of insurability satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.

For Payroll Deduction Authorization By the Employee

I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon, and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

(Continued on Following Page)

Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)

The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. The Employee understands that he or she has the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)	Share %
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			TOTAL:	100%

Signature(s): The employee must sign in all cases. The person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Sign Here

Employee Signature _____ Print Name _____ Date Signed (Mo./Day/Yr.) _____

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of **METROPOLITAN LIFE INSURANCE COMPANY.**

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies.

How We Learn about You: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:

- Ask for a medical exam
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about your finances, employment, hobbies, mode of living, work history, and driving record.

The information may be kept by the consumer reporting agency and later given to others as permitted by law**.** The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect What We Know About You: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to your MetLife Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. Please identify the specific product or service you are writing about.

Delta College
Payroll Office

Memo

To: New Hires

From: Payroll Manager

Re: Payroll Options

Welcome to Delta College! Delta offers two convenient methods of payment for your payroll needs—Direct Deposit to the bank of your choosing or a Pay Distribution Service through Money Network that allows you to access your payroll through a Money Network debit card or Money Network checks.

Please read the following Pre-Paid Acquisition Disclosures and complete the Employee Pay Selection Record along with the Direct Deposit form, if applicable.

If you select Direct Deposit, please make sure to include a voided check or a letter from your financial institution verifying your account information. Payment will be received in your account on pay day. No extra steps are necessary.

If you select the Pay Distribution Service through Money Network, your Money Network debit card, checks and information packet will be available for pick-up at the Cashier's window in the B-Wing of Delta's Main Campus. The Payroll Office will contact you at your delta.edu email address and let you know when the packet is available for pick-up. The card will remain at the Cashier's Office until pick-up unless otherwise agreed upon. If you have questions or need to make alternative arrangements, please contact the Payroll Office at payroll@delta.edu.

Important: If you select the Money Network Service, you will be enrolled in an Employer Program Account. If you do not receive wage, salary or other compensation loads from Delta for 60 consecutive days, your Employer Program Account may be converted to a MyMoneyNetwork Account. If this occurs, a Monthly Maintenance Fee will apply to your account for each cycle in which deposits totaling at least $400.00 are not made. If you are an intermittent or temporary employee, please consider if this is the best option for you. If any changes occur with your Money Network account, it is your sole responsibility to contact the Payroll Office to prevent a delay in pay.

If you have any questions, please contact the Payroll Office at payroll@delta.edu or 989-686-9388.

You have the right to change your method of payment at any time. However, please allow two weeks to incorporate the change.

PREPAID DISCLOSURES

Payroll Card Short Form

You do not have to accept this payroll card.
Ask your employer about other ways to receive your wages.

Monthly fee	Per purchase	ATM withdrawal	Cash reload
$0	**$0**	**$0** in-network **$3.25** out-of-network	**$5.95***

ATM balance inquiry (in-network or out-of-network)	$0 or $3.25
Customer service	$0 per call
Inactivity	$0

We charge 12 other types of fees. Here is one of them:

ATM decline (in-network or out-of-network)	$0 or $3.25

* This fee can be lower depending on how and where the card is used.

No overdraft/credit feature
Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit *cfpb.gov/prepaid*.
Find details and conditions for all fees and services on the next page, or call **888-913-0900** or visit ***moneynetwork.com***.

Money Network Service Employer Program and MyMoneyNetwork Program. Cards issued by MetaBank®, National Association, Member FDIC. Card is serviced by Money Network Financial, LLC

List of all fees (Fee Schedule) for the Money Network® Service Employer Program and MyMoneyNetwork Program

Fees are deducted from your Account for the services and transactions below. Upon your enrollment in the Money Network Service, you will have an Employer Program Account and fees under "Employer Program" column heading apply. If you do not receive loads from your Employer for at least 60 consecutive days, your Employer Program Account may convert to a MyMoneyNetwork Account. Fees under "MyMoneyNetwork Program" column heading apply to a MyMoneyNetwork Account.

All Fees	Employer Program	My MoneyNetwork Program	Details
Monthly Usage			
Account Opening, Check, and Card Receipt	$0.00	$0.00	No fee for Account Opening, Checks, and initial Card.
Monthly Maintenance Fee	Not Applicable	$5.00	Fee is waived if you live in NY. Fee is waived in any Monthly Statement Cycle in which Account loads total $400 or more.
Add Money			
Payroll Deposit	$0.00	$0.00	Funds loaded by your Employer.
ACH Deposit of Other Funds	$0.00	$0.00	Loads of other types of funds or payments, e.g. a tax refund.
Spend Money			
Signature Debit Transactions	$0.00	$0.00	Select "Credit" or sign at point-of-sale (**POS**). Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to International Transactions.
PIN Debit Transactions	$0.00	$0.00	Select "Debit" and enter PIN at POS; cash back option at participating merchants. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to International Transactions.
Money Network® Check	$0.00	$0.00	Participating check cashing locations do not charge fees to cash Money Network Checks. To find these locations, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service. Non-participating check cashing locations may charge fees that are not monitored by us. Check cashing locations may also limit the dollar amount of checks they will cash.
Get Cash or Send Cash			
ATM Withdrawal Fee or ATM Decline Fee | In-Network	$0.00	$0.00	Withdrawal or Decline from ATM that is a part of our network. If you live in CT or IL, we will waive our fee for the first two ATM Declines (In-Network, Out-of-Network, or Non-US) in a calendar month. To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.
ATM Withdrawal Fee| Out-of-Network ATM Decline Fee | Out-of-Network	$3.25	$3.25	This is our fee. We waive our Out-of-network ATM Decline Fee if you live in NY. If you live in CT or IL, we will waive our fee for the first two ATM Declines (In-Network, Out-of-Network, or Non-US) in a calendar month. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
Bank Teller Over the Counter Cash Withdrawal	$0.00	$0.00	At banks displaying the card association logo on your Card's front side. This is our fee. You may also be charged a fee by the bank. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to International Transactions.
Transfer to Customer Bank Fee	$3.00	$3.00	Domestic ACH transactions are subject to additional terms that are disclosed when a transaction is initiated.
International ACH Withdrawal Fee	$7.00 plus 3.5% of the exchange rate	$7.00 plus 3.5% of the exchange rate	This transaction allows you to transfer funds via ACH to an international bank account. We charge transfer fees consisting of a flat fee of up to $7.00 plus a mark-up on the exchange rate of up to 3.5%. The transfer fees may be less depending on the amount transferred and market conditions. Applicable transfer taxes will also be charged. The exact amount of transfer fees and transfer taxes charged by us will be disclosed to you before you complete the transaction. Your transaction is subject to an exchange rate conversion, and may be subject to additional fees and taxes, from 3rd parties. Recipient's financial institution may also charge fees and taxes. We do not monitor exchange rates or fees established by 3rd parties and these amounts are subject to change. These transactions are subject to additional terms that are disclosed when a transaction is initiated. See website for more information. You may call Customer Service for assistance.
Information			
Monthly Paper Statement	$0.00	$0.00	Obtain Account activity without fee via Mobile App (data rates may apply), moneynetwork.com, or Customer Service.
Customer Service	$0.00	$0.00	24/7 toll free Account access, including Account balance inquiries.
ATM Balance Inquiry Fee | In-Network	$0.00	$0.00	To find in-network ATMs, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.

ATM Balance Inquiry Fee | Out-of-Network	$3.25	$3.25	This is our fee. You may also be charged a fee by the ATM operator, even if you do not complete a transaction.
Using Your Card Outside the U.S. (International Transactions)			
ATM Withdrawal INT Fee (Non-U.S.)	$3.25	$3.25	This is our fee. We waive our ATM Decline INT (Non-US) Fee if you live in NY. If you live in CT or IL, we will waive our fee for the first two ATM Declines (In-Network, Out-of-Network, or Non-US) in a calendar month. You may also be charged a fee by the ATM operator, even if you do not complete a transaction. Currency Conversion Assessment Fee, International Service Assessment, and/or Cross Border Assessment may also apply to these transactions.
ATM Decline INT Fee (Non-U.S.)			
ATM Balance Inquiry INT Fee (Non-U.S.)			
Visa International Service Assessment (applies if transaction is initiated in non-U.S. dollars and a currency conversion rate applies)	2.0%	2.0%	Of the U.S. dollar amount of each International Transaction made with a Visa branded card. Only one of these fees may apply to your transaction and be assessed. See *Using Your Account and Card - International Transactions* in your Agreement's terms and conditions for additional information. Transaction fees on your statement will include these fees if they apply to your transaction.
Visa Cross Border Assessment *(applies if transaction is initiated in U.S. dollars by a merchant with a non-U.S. country Code)*	0.8%	0.8%	
Mastercard Currency Conversion Assessment Fee (applies if transaction is initiated in non-U.S. dollars)	0.2%	0.2%	Of the U.S. dollar amount of each International Transaction made with a Mastercard branded card. Either or both of these fees may apply to your transaction and be assessed. See *Using Your Account and Card - International Transactions* in your Agreement's terms and conditions for additional information. Transaction fees on your statement will include these fees if they apply to your transaction.
Mastercard Cross Border Assessment Fee *(applies if transaction is initiated with merchant with non-U.S. country code)*	2.0%	2.0%	
Other			
Reissuance of Lost/Stolen Card	$6.00	$6.00	Reissued Card shipped via U.S. mail 7-10 business days after order placed. One replacement Card provided at no charge each calendar year.
Priority Shipping Fee	$24.00	$24.00	Additional fee to ship replacement Card 4-7 business days after order placed. Reissuance of Card Fee also applies.
Request Secondary Account	$0.00	$0.00	Request an additional account for family or dependents.
Transfer Funds to Secondary Account	$0.00	$0.00	Transfer of funds to Secondary Account.
Money Network Check Stock Order	$0.00	$0.00	Shipped 7-10 business days after order placed. Up to 30 checks per order.
3rd Party Fees (We do not charge you these fees.)			
Cash Deposit at Reload Provider	$5.95	$5.95	3rd party fees, known to be up to $5.95 as of 8/15/2018, may apply when reloading your Card at reload providers. To find reload providers, use the locator on our Mobile App (data rates may apply) or at moneynetwork.com, or call Customer Service.
Deposit Check Funds via Mobile App | Standard	$0.00	$0.00	A 3rd party provides this service subject to its enrollment process, terms, conditions, fees, and privacy policy. Checks are subject to the 3rd party's approval in their sole discretion; dollar limits and other restrictions apply. Approved checks are loaded net of applicable fees. **Expedited Service**: 3rd party fees are 1% of approved check amount for preprinted payroll & government checks and 4% of approved check amount for other check types, with a $5 minimum fee. 3rd party approval process usually takes 3-5 minutes but may take an hour. Most issuers post funds within 24 hours. **Standard Service**: No 3rd party fee for 10 days delayed funding. See Mobile App (message and data rates may apply) for more information.
Deposit Check Funds via Mobile App | Expedited • Preprinted payroll & government checks • Other check types	Greater of: • 1% or $5.00 • 4% or $5.00	Greater of: • 1% or $5.00 • 4% or $5.00	
Additional Disclosures			
Your funds are eligible for deposit insurance up to the applicable limits by the Federal Deposit Insurance Corporation ("FDIC"). Your funds will be held at MetaBank®, N.A. or placed by MetaBank as custodian at one or more participating FDIC-insured banks (each a "Program Bank"). In the event the FDIC were to be appointed as a receiver for MetaBank or a Program Bank, your funds, aggregated with any other funds you have on deposit at such institution, would be eligible to be insured up to $250,000 for each legal category of account ownership, subject to compliance with FDIC deposit insurance requirements. You are responsible for monitoring the total amount of all direct or indirect deposits held by you or for you with MetaBank and the Program Banks for purposes of monitoring the amount of your funds eligible for coverage by FDIC insurance. To assist with calculating your FDIC deposit insurance coverage, the FDIC has an Electronic Deposit Insurance Estimator available at https://edie.fdic.gov. For more information, see also https://www.fdic.gov/deposit/deposits/prepaid.html. No overdraft/credit feature. Contact Customer Service by calling 888-913-0900, by mail at 2900 Westside Pkwy, Alpharetta, GA 30004, or visit moneynetwork.com. For general information about prepaid accounts, visit cfpb.gov/prepaid. If you have a complaint about a prepaid account, call the Consumer Financial Protection Bureau at 1-855-411-2372 or visit cfpb.gov/complaint.			
META D1P 22/3			

Employee Pay Selection Record

DELTA COLLEGE ("**Employer**") offers two options to receive your pay, Direct Deposit or the Money Network® Service. Please review these options and make your selection below.

Option 1: **DIRECT DEPOSIT** Employer will pay all of my net pay as selected below ("**Direct Deposit**") into the account (the "**Account**") at the financial institution with the routing and account numbers and account type (collectively, "**Account Information**") I have provided separately to Employer according to Employer's procedure.

Option 2: **MONEY NETWORK SERVICE**

PLEASE REVIEW THE MONEY NETWORK SERVICE PREPAID DISCLOSURES PROVIDED WITH THIS PAY SELECTION RECORD.

Employer will pay all of my net pay using the Money Network Service. The Money Network Service Welcome Packet contains the Terms and Conditions that apply to the Money Network Service, the detailed fee schedule for the Money Network Service, and other important disclosures. Once I consent to those terms and contract for the Money Network Service by activating my Money Network Service account by following the instructions in the Welcome Packet, I may begin to use the Money Network Service. There is no monthly service charge for the Money Network Service as long as I am employed by Employer. As further explained in the Terms and Conditions, I can access my total net pay each pay period for free using the Money Network™ Check ("**Check**") or optional Money Network Payroll Debit Card ("**Card**"). The Check is a check that I can complete and deposit into my personal bank account, cash for free at Money Network check-cashing partners, or use for other purposes such as paying bills. Third party check cashing services may charge transaction or other fees. Many transactions using the Card are free, but Money Network Service fees or third party fees apply to some Card transactions and services. Options are available that allow me to check my account balance for free.

I HEREBY ELECT TO HAVE MY PAY DISTRIBUTED AS INDICATED:
(*REQUIRED:* MAKE ONE CHOICE BY CHECKING THE 1 OR 2 BOX AND WRITING YOUR INITIALS ABOVE YOUR SELECTION BELOW)

Option 1 ☐ _____ Initials	*OR*	Option 2 ☐ _____ Initials
DIRECT DEPOSIT		MONEY NETWORK SERVICE

I authorize Employer to pay me by Direct Deposit or the Money Network Service, according to the selection I checked and initialed above. This Employee Pay Selection Record ("**PSR**") and Account Information (defined above) must be submitted to Employer within three (3) business days (thirty (30) days in Michigan) of receiving notice to do so. **If I fail to make a selection for Direct Deposit or the Money Network Service, or to provide Account Information (if applicable), I agree that I will be paid using the Money Network Service**. However, I understand that I can change my pay selection at any time in the future by submitting a new PSR and Account Information (if applicable) according to Employer's procedure (subject to the time it takes Employer to implement the change). My election will remain in effect unless Employer and/or Program Manager cancels this arrangement. In case of payment of funds to which I am not entitled, I authorize Employer to withdraw such funds from the Account or the Money Network Service. To help the government fight the funding of terrorism and money laundering activities, Federal law requires financial institutions to verify and record identity information before opening an account such as the account provided when you enroll in the Money Network Service. To permit this identification so that my pay to be placed in such an account, I authorize Employer to share my name, address, date of birth, Social Security Number, identification documents, and related personal information with Money Network and the issuing bank.

			EMPLOYER USE ONLY
Signature*	Printed Name*	Date*	Employee ID Number

**** Required***

Delta College

DIRECT DEPOSIT AUTHORIZATION

EMPLOYEE INFORMATION

Employee Name (Print): _____ Employee ID # or SSN: _____

PLEASE SELECT ONE:

☐ Initial Request ☐ Change Bank / Account # ☐ Add / Delete Secondary Account

DIRECT DEPOSIT ACCOUNT INFOMATION

Name of Financial Institution: _____

Routing Number: _____ Account Number: _____ ☐ Checking ☐ Savings

☐ Full Check ☐ Balance ☐ Partial Amount: $_____

SECONDARY ACCOUNT INFORMATION (OPTIONAL):

Name of Financial Institution: _____

Routing Number: _____ Account Number: _____ ☐ Checking ☐ Savings

Dollar Amount: $_____

REQUIRED VERIFICATION

Please attach a voided check or verification of your routing and account number(s) by your financial institution for each account listed above. This form must also be completed in its entirety. Failure to do so may cause a delay in receiving your pay.

AUTHORIZATION

I hereby authorize Delta College and the financial institution(s) listed above to deposit my pay automatically to my account each payday. Adjusting entries to correct errors are also authorized. This authority will remain in effect until Delta College receives written notice from me to cancel or change this authorization.

Employee Signature: _____ Date: _____

DELTA COLLEGE EMPLOYEES
ACKNOWLEDGEMENT AND RELEASE FORM
HEPATITIS B VACCINATION

Only complete if you are a Category A Employee

Please check with your supervisor for clarification if you are unsure whether or not your position is considered Category A.

The following jobs have been identified as requiring procedures or tasks which involve exposure or reasonably anticipated exposure to blood or other potentially hazardous material:

• Public Safety	• Coaches
• Dental Assisting - Faculty, Staff & Students	• Dental Hygiene - Faculty, Staff & Students
• Exploratory Teaching - Faculty, Staff & Students	• Facilities Management Staff
• Fire Science Technology – Faculty, Staff & Students	• Multimedia Learning Lab (MLL) Technicians
• Nursing LPN - Faculty, Staff & Students	• Nursing RN - Faculty, Staff & Students
• Phlebotomy - Faculty, Staff & Students	• Designated Ctr Personnel -Planetarium, Saginaw & Midland
• Respiratory Care - Faculty, Staff & Students	• Surgical Technology - Faculty, Staff & Students
• Lifeguards	• Operations Assistants
• Science courses with microbiology components and/or involving human specimen collection - Faculty, Staff & Students involved in BIO 102 and BIO 203	

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to me.

IF YOU CHOOSE TO DECLINE….

If I decline the vaccination at this time, I understand that I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I still have occupational exposure risk and want to be vaccinated, I can receive the vaccine series at no charge to me.

MAKE YOUR DECISION, CHECK ONE OF THE FOLLOWING:

_____ I have ALREADY RECEIVED the hepatitis B vaccine and decline the vaccination provided by Delta College.

_____ I WOULD LIKE TO RECEIVE the hepatitis B vaccine series provided by Delta College.

_____ I DECLINE the vaccine and release Delta College from liability should I become infected.

EMPLOYEE'S NAME (print): _____

EMPLOYEE'S SIGNATURE: _____ DATE:_____

DEPARTMENT/DIVISION: _____ PHONE: _____