

**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.

**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 <a href="http://www.ssa.gov">www.ssa.gov</a> .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

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

<b>Step 3: Claim Dependent and Other Credits</b>	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 . . . . .	<b>3</b>	\$ _____
<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> 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 . . . . .	<b>4(a)</b>	\$ _____
	(b) <b>Deductions.</b> 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 . . . . .	<b>4(b)</b>	\$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each <b>pay period</b> . . . . .	<b>4(c)</b>	\$ _____

**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)

Department of  
TaxationIT 4  
Rev. 12/20**Employee's Withholding Exemption Certificate**

Submit form IT 4 to your employer on or before the start date of employment so your employer will withhold and remit Ohio income tax from your compensation. If applicable, your employer will also withhold school district income tax. You must file an updated IT 4 when any of the information listed below changes (including your marital status or number of dependents). You should contact your employer for instructions on how to complete an updated IT 4. **Your employer may require you to complete this form electronically.**

**Section I: Personal Information**

Employee Name:	Employee SSN:
Address, city, state, ZIP code:	
School district of residence (See <i>The Finder</i> at tax.ohio.gov):	School district number (####):

**Section II: Claiming Withholding Exemptions**

1. Enter "0" if you are a dependent on another individual's Ohio return; otherwise enter "1" .....
2. Enter "0" if single or if your spouse files a separate Ohio return; otherwise enter "1" .....
3. Number of dependents .....
4. Total withholding exemptions (sum of line 1, 2, and 3) .....
5. Additional Ohio income tax withholding per pay period (optional) .....\$ .....

**Section III: Withholding Waiver**

I am **not** subject to Ohio or school district income tax withholding because (check all that apply):

- ☐ I am a full-year resident of Indiana, Kentucky, Michigan, Pennsylvania, or West Virginia.
- ☐ I am a resident military servicemember who is stationed outside Ohio on active duty military orders.
- ☐ I am a nonresident military servicemember who is stationed in Ohio due to military orders.
- ☐ I am a nonresident civilian spouse of a military servicemember and I am present in Ohio solely due to my spouse's military orders.
- ☐ I am exempt from Ohio withholding under R.C. 5747.06(A)(1) through (6).

**Section IV: Signature (required)**

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

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 <div></div>		Employee's Email Address			Employee's Telephone Number
<b>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.</b>		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
		<input type="checkbox"/> 1. A citizen of the United States				
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.) <div></div>				
		<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2. and 3. above</b> ) authorized to work until (exp. date, if any) <div></div>				
		If you check <b>Item Number 4.</b> , enter one of these:				
		USCIS A-Number <div></div>	OR	Form I-94 Admission Number <div></div>	OR	Foreign Passport Number and Country of Issuance <div></div>
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	<div></div>		<div></div>		<div></div>	
Issuing Authority	<div></div>		<div></div>		<div></div>	
Document Number (if any)	<div></div>		<div></div>		<div></div>	
Expiration Date (if any)	<div></div>		<div></div>		<div></div>	
Document Title 2 (if any)	<div></div>	<b>Additional Information</b> <div></div>				
Issuing Authority	<div></div>					
Document Number (if any)	<div></div>					
Expiration Date (if any)	<div></div>					
Document Title 3 (if any)	<div></div>					
Issuing Authority	<div></div>					
Document Number (if any)	<div></div>					
Expiration Date (if any)	<div></div>					
<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.						
<b>Certification:</b> 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): <div></div>	
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			

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		LIST B	LIST C
Documents that Establish Both Identity and Employment Authorization	OR	Documents that Establish Identity	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 <b>Section 7</b> and <b>Section 13</b> of the M-274 on <a href="https://uscis.gov/i-9-central">uscis.gov/i-9-central</a> .  The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4.</b> document, not a List C document.
		8. Native American tribal document	
		9. Driver's license issued by a Canadian government authority	
		<b>For persons under age 18 who are unable to present a document listed above:</b>	
		10. School record or report card	
		11. Clinic, doctor, or hospital record	
		12. Day-care or nursery school record	
<b>Acceptable Receipts</b>  May be presented in lieu of a document listed above for a temporary period.  For receipt validity dates, see the M-274.			
<ul style="list-style-type: none"><li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li><li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li><li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li></ul>	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.

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

Employee Name \_\_\_\_\_ Employee ID# \_\_\_\_\_

Employer Name \_\_\_\_\_ Employer ID# \_\_\_\_\_

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

### Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

### Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

### For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at [www.socialsecurity.gov](http://www.socialsecurity.gov). You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

**I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.**

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_



STATE TEACHERS  
RETIREMENT SYSTEM  
OF OHIO

275 East Broad Street  
Columbus, OH 43215-3771  
888-535-4050  
www.strsoh.org/employer

## MEMBER INFORMATION

**EMPLOYERS: PLEASE DO NOT SEND THIS FORM TO STRS OHIO.** Use this optional form to gather required information from new employees in order to complete new hire or reemployed retiree notifications. This information **must** be sent in a properly formatted electronic file via secure file upload or electronically in ESS. See the STRS Ohio Employer Website for record layouts.

Members: Please complete the information below and return to your employer within 10 days of your first workday.

### Section 1 — Employee Information

Social Security no. \_\_\_\_\_

Name \_\_\_\_\_

Birth date \_\_\_\_\_ ☐ Male ☐ Female

Address \_\_\_\_\_

City, state, ZIP code \_\_\_\_\_

Primary email address \_\_\_\_\_

☐ Cell phone or ☐ Home phone \_\_\_\_\_

First date on payroll with this employer \_\_\_\_\_ (Retired employees should indicate first day worked with this employer after retirement date.)

Are you currently receiving a monthly retirement benefit from an Ohio public employer or an alternative retirement plan (ARP)? ☐ Yes ☐ No If yes, please complete Section 2.

### Section 2 — Retired Employee

Only complete if you are receiving a monthly retirement benefit from an Ohio public employer or an ARP.

Retirement date \_\_\_\_\_

Type of retirement benefit:

☐ Service retirement ☐ Disability ☐ ARP (Allowance)

Which retirement system pays your monthly retirement benefit?

- |  |  |
|--|--|
| <input type="checkbox"/> STRS — State Teachers Retirement System of Ohio   | <input type="checkbox"/> OP&F — Ohio Police & Fire Pension Fund  |
| <input type="checkbox"/> OPERS — Ohio Public Employees Retirement System   | <input type="checkbox"/> SHP — Highway Patrol Retirement System  |
| <input type="checkbox"/> SERS — School Employees Retirement System of Ohio | <input type="checkbox"/> CRS — City of Cincinnati Retirement System  |
|  | <input type="checkbox"/> ARP — Alternative Retirement Plan (option only for college and university retirees) |

### School Use Only

College and university employers: Is this employee eligible for an ARP? ☐ Yes ☐ No

# Warren Local Schools

Kyle Newton, Superintendent

Melcie Wells, Treasurer

220 Sweetapple Road  
Vincent, Ohio 45784

740-678-2366  
[www.warrenlocal.org](http://www.warrenlocal.org)



To: Warren Local Employees:

The State of Ohio has established a reporting system whereby public employees can file complaints of fraud and misuse of public funds by public offices or officials. Complaints can be made using any of the following methods.

1. Mail a written complaint to:

Ohio Auditor of State's Office  
Special Investigations Unit  
88 East Broad St. PO #1140  
Columbus, OH 43215

2. Report a complain online by going to:

<http://www.ohioauditor.gov/fraud.html>, then click on **Report It Now**

3. Report a complaint by telephone by calling:

1-866-FRAUD-OH (866-372-8364)

Sincerely,

Brittany Lee  
Payroll/Benefits Manager  
Warren Local School District  
740-678-2366 x115  
[brittany.lee@warrenlocal.org](mailto:brittany.lee@warrenlocal.org)

I AM A WARRIOR

February 2020

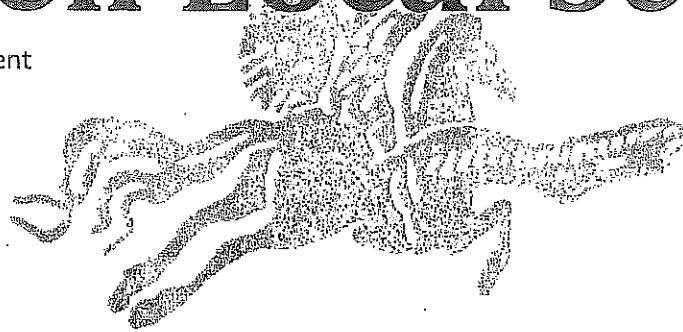
# Warren Local Schools

Kyle Newton, Superintendent

Melcie Wells, Treasurer

220 Sweetapple Road  
Vincent, Ohio 45784

740-678-2366  
www.warrenlocal.org



## ACKNOWLEDGEMENT OF RECEIPT OF AUDITOR OF STATE

### FRAUD REPORTING-SYSTEM INFORMATION

Pursuant to Ohio Revised Code 117.103(B)(1), a public office shall provide information about the Ohio fraud-reporting system and the means of reporting fraud to each new employee upon employment with the public office.

Each new employee has thirty days after beginning employment to confirm receipt of this information.

By signing below, you are acknowledging Warren Local Schools provided you information about the fraud-reporting system as described by Section 117.103(A) of the Revised Code, and that you read and understand the information provided. You are also acknowledging you have received and read the information regarding Section 124.341 of the Revised Code and the protections you are provided as a classified or unclassified employee if you use the before-mentioned fraud reporting system.

I, \_\_\_\_\_, have read the information provided by my employer regarding the fraud-reporting system operated by the Ohio Auditor of State's office. I further state that the undersigned signature acknowledges receipt of this information.

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PRINT NAME AND TITLE

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PLEASE SIGN

---

DATE





# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 6-30-2023)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.<sup>1</sup>

**Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

### How Can I Get More Information?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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<sup>1</sup> An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Warren Local School District		4. Employer Identification Number (EIN) 31-6401073	
5. Employer address 220 Sweetapple Rd		6. Employer phone number 740-678-2366	
7. City Vincent		8. State OH	9. ZIP code 45784
10. Who can we contact at this job? Brittany Lee, Assistant Treasurer			
11. Phone number (if different from above)		12. Email address brittany.lee@warrenlocal.org	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

# Warren Local Schools



Kyle R. Newton, Superintendent

220 Sweetapple Road  
Vincent, Ohio 45784

Melcie A. Wells, Treasurer

740-678-2366  
www.warrenlocal.org

## ACKNOWLEDGEMENT OF RECEIPT OF NEW HEALTH INSURANCE

### MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

By signing below, you are acknowledging Warren Local Schools provided you information about the New Health Insurance Marketplace Coverage Options and Your Health Coverage.

I, \_\_\_\_\_, have read the information provided by my employer regarding the New Health Insurance Marketplace Coverage Options and Your Health Coverage. I further state that the undersigned signature acknowledges receipt of this information.

---

PRINT NAME AND TITLE

---

PLEASE SIGN

---

DATE

September 2019

I AM A WARRIOR



# Warren Local School District

## AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYROLL DEPOSITS (ACH CREDITS)

All payroll deposits are done electronically.

Company Name: Warren Local School District

I (Enrollee) hereby authorize Warren Local School District-Payroll, hereinafter called the Company, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries in error to my checking and/or savings indicated below at the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Each enrollee is allowed a maximum of four individual accounts in which to automatically deposit funds in conjunction with payroll. Account modifications can be no more frequent than on a monthly basis. Any error performed in association with inaccurate account/routing numbers provided by the enrollee, shall be the sole responsibility of the enrollee. In such event, the enrollee will hold the Company harmless.

### DEPOSITORY INFORMATION

✓ ✓

Depository Name	City of Local Branch	State	Savings	Checking	Account Number	Routing Number	Percentage or Flat Amount

\*\*\*\*\*Please attach a voided check and/or a deposit slip for each corresponding account. \*\*\*\*\*

This authorization is to remain in full force and effect until the Company has received written notification from me of its termination in such time and in such manner as to afford the Company and Depository a reasonable opportunity to act upon my termination request.

Name (printed): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Email Address (to receive your pay stub): \_\_\_\_\_

NOTE: ALL WRITTEN CREDIT AUTHORIZATIONS SHOULD PROVIDE THAT THE RECEIVED MAY REVOKE THE AUTHORIZATION ONLY BY NOTIFYING THE ORIGINATOR IN THE MANNER SPECIFIED IN THE AUTHORIZATION.