APPENDIX N

Acknowledgement of Receipt of Retirement Information

I received the 13-page information and election package regarding the first-tier and second-tier retirement plans (PERS-MEM-42 [A,B,C])

Signature	**Social Security Number**
Printed Name	**PERS Membership Date**
Date	**State Department**

This form must be completed, signed, and left with your personnel clerk who will forward it to PERS.

This is **not** an election document. The election document for the first-tier retirement plan is at the back of this information package.

The information and election package was given to the above employee

on_____ by_____
Date **Personnel Office Staff**

( ) _____
Public Telephone Number

Member Services Division, Unit 821
P.O. Box 942704
Sacramento, CA 94229-2704

PERS-MEM-42A
(Rev. 11-1-88)

Information Practices Statement

The Information Practices Act of 1977 and the Federal Privacy Act require the Public Employees' Retirement System to provide the following information:

The information requested is collected pursuant to Government Code sections (20000, et seq.) and will be used for administration of the Board's duties under the retirement law, the Social Security Act, and the Public Employees' Medical and Hospital Care Act. Submission of the requested information is mandatory. Failure to supply the information may result in PERS being unable to perform its functions regarding your status. Portions of this information may be transferred to: state and public agency employers, California State Attorney General, Office of the State Controller, Teale Data Center, Franchise Tax Board, Internal Revenue Service, Workers' Compensation Appeals Board, State Compensation Insurance Fund, County District Attorneys, Social Security Administration, beneficiaries of deceased members, physicians, insurance carriers, and various vendors who prepare microfiche/microfilm for PERS. Disclosure to these entities is done in strict accordance with current statutes regarding confidentiality.

You have the right to review your membership file maintained by PERS. For questions concerning your rights under the Information Practices Act of 1977, please contact the Information Coordinator, PERS, 400 P Street, P.O. Box 942702, Sacramento, CA 94229-2702.

APPENDIX N (continued)

Election Document for First-Tier Retirement Plan

To be valid, this document must be completed and forwarded to PERS within one year of your date of membership.

I certify that I have read and understand the information that accompanied this document, and I hereby elect to enroll in the first-tier retirement plan for state miscellaneous and industrial service from my date of membership. I understand that contributions for future service will be deducted from my payroll warrants and that I must pay contributions, plus interest, for service since my date of membership.

Signature _____

Printed Name _____

Social Security Number _____

Date _____

Mailing Address _____

Employer _____

City _____

State, Zip _____

Failure to file this form with PERS within one year of your date of membership will be deemed an irrevocable election by you to be enrolled in the second-tier retirement plan for all future qualifying state miscellaneous and industrial service.

Mail this form to:
Public Employees' Retirement System
Member Services Division, Unit 821
P.O. Box 942704
Sacramento, CA 94229-2704

PERS-MEM-42C
(Rev. 11-1-88)

White Copy: Return To PERS • Yellow: Retain For Your Files

APPENDIX O

CALIFORNIA STATE PERSONNEL BOARD

STATE EMPLOYEE RACE/ETHNICITY QUESTIONNAIRE

(For All New Hires)

300-1070 St Empl Race/Ethnic Quest (9/82)

Date

INSTRUCTIONS:

1. This self-identification questionnaire is part of the new employee package. Self-identification means each employee has the opportunity to select which race/ethnic group he/she most closely identifies with. Complete promptly and return to the Personnel Office with your other hiring documents.

EMPLOYEE'S NAME *(print)*	SOCIAL SECURITY NUMBER	SEX ☐ MALE ☐ FEMALE

2. Please check the one box below which best describes your race/ethnicity and enter the one letter chosen (A through T or X) on this line: _____

If Hispanic, check:

A. ☐ Mexican, Mexican/American, Chicano
B. ☐ Puerto Rican
C. ☐ Cuban
D. ☐ Any Other Spanish/Hispanic

If Not Hispanic, check:

E. ☐ White
F. ☐ Black
G. ☐ Filipino
H. ☐ American Indian
_____ *(Specify Tribe)*
I. ☐ Japanese
J. ☐ Chinese
K. ☐ Korean
L. ☐ Vietnamese
M. ☐ Asian Indian
N. ☐ Eskimo
O. ☐ Aleut
P. ☐ Hawaiian
Q. ☐ Samoan
R. ☐ Guamanian/Chamorro
S. ☐ Other Asian
T. ☐ Other Pacific Islander
X. ☐ Other, Not Listed

3. Please check the method of identification

☐ A. Self-Identification
☐ B. Department Designation (This is only used if the employee does not self-identify.)

PRIVACY STATEMENT FOR RACE/ETHNICITY QUESTIONNAIRE

AGENCY NAME: State Personnel Board Public Employment and Affirmative Action Division

UNIT RESPONSIBLE FOR MAINTENANCE: The Personnel Office of the employing State department.

AUTHORITY/PURPOSE: Government Code Section 19792 states that "The State Personnel Board shall: . . . (h) Maintain a statistical information system designed to yield the data and the analysis necessary for the evaluation of progress in affirmative action and equal employment opportunity with the state civil service . . ."

The data is encoded by the department Personnel Office and becomes part of the Employment History System kept by the State Controller's Office. It is shared only with the State Personnel Board and the employing department. No other disclosures on an individual-identifiable basis are made.

PROVIDING INFORMATION: It is preferable for each employee to indicate which race/ethnic group they most closely associate with.

EFFECTS OF NOT PROVIDING THE INFORMATION: Since Government Code Section 19792 requires the collection of race/ethnic origin from all employees, your Personnel Office will designate a race/ethnic code for you should you decline to self-identify.

ACCESS: The individual can access his/her own records through their Personnel Office.

APPENDIX P

VHA CERTIFICATE

☐ START ☐ CHANGE ☐ STOP

EFF DATE _____

(To be completed by soldier) **PART I - IDENTIFICATION AND HOUSING INFORMATION**

1. SOLDIER

a. NAME (Last, First, Middle Initial)

b. PAY GRADE

c. SOCIAL SECURITY NUMBER

d. DUTY LOCATION OR HOMEPORT

(1) DUTY STATION NAME

(2) CITY AND STATE

(3) DUTY PHONE

2. SOLDIER'S RESIDENTIAL ADDRESS (Street, Apt No. City, County, and State)

3. DEPENDENT'S RESIDENTIAL ADDRESS (Street, Apt No. City, County, and State) (If other than block 2 above)

4. EFFECTIVE DATE OF LEASE/RENTAL/SALE AGREEMENT (YYMMDD)

a. MEMBER'S

b. DEPENDENT'S (Complete if block 3 is filled out)

5. To determine if you are a "sharer", enter an X in the appropriate box at the left for each category of individual occupying your residence. For each category you mark with an X, enter the total number of individuals in that category in the box at the right.

X		NAME	SSN	SERVICE	NO.
	a. MYSELF				
	b. Spouse who is also a soldier. (Enter 1 and provide the following data indicated.)				
	c. Spouse or other dependent who is a Federal civilian employee entitled to a living quarters allowance. (Enter 1)				
	d. Other Servicemembers entitled to basic allowance for quarters (Enter total number).				
	e. Excluding dependents, any others not covered above who pay a portion of the Rent, Mortgage, and/or utilities (Enter total number)				
	f. Enter the total of 5a through 5e above. (Do not count dependents unless covered by category c. If the result exceeds "1" you are considered a "sharer".				

6. EXPENSES, IF AUTHORIZED, I AM REQUESTING VHA BASED ON:

☐ My permanent duty station; ☐ My dependent's location; ☐ Both my permanent duty station and dependent's location.

a. Monthly Ownership Expenses:

(1) Principal _____ | _____

(2) Interest _____ | _____

(3) Taxes _____ | _____

(4) Insurance _____ | _____

(5) Other (Specify) _____ | _____

Totals _____ | _____

b. Monthly Rental Expenses:

(1) Rent _____ | _____

(2) Insurance _____ | _____

(3) Other (Specify) _____ | _____

Totals _____ | _____

Variable Housing Allowance (VHA) was implemented to provide military members an allowance based on the difference between a Soldier's BAQ and the actual rent a Soldier pays, not to exceed the maximum VHA payable. If changes occur in residency, dependency, number of Soldiers sharing rent, or monthly rent, notify command/personnel/finance officer as soon as possible. The penalty for making a fraudulent claim/statement is a maximum fine of $10,000.00 or maximum imprisonment of five years, or both (18 U.S. Code, Section 287).

I certify that I fully understand the condition of entitlement to VHA and my responsibility for promptly notifying appropriate officials when changes affecting my entitlement occur. I further understand that I must recertify my VHA entitlement annually or as requested.

_____ Soldier's (Signature) _____ (Date)

_____ Commander/CDR (Signature) _____ (Date)

PART II - COMPUTATION

7. VHA ELIGIBILITY COMPUTATION:

COLUMN A		COLUMN B	
a. BAQ	_____	h. Enter amount from 7d.	_____
OR			
b. FSA TYPE-I	_____	i. Enter amount from 7g.	_____
c. VHA	_____	j. Subtract 7i from 7h. Enter difference.	_____
d. TOTAL	_____ (Enter total in 7h)	k. Enter amount from 7c.	_____
		l. Subtract 50% of 7j.	_____
e. HOUSING COSTS	_____	m. Subtract 7l from 7k. Enter difference. This is the soldier's VHA entitlement.	_____
f. UTILITY/MAINTENANCE EXPENSE			
g. TOTAL	_____ (Enter total in 7i)		

If amount in 7g is greater than 7d, STOP HERE.

USAFAC FORM 5274-R
FEB 86

APPENDIX Q

EMPLOYMENT ELIGIBILITY VERIFICATION (Form I-9)

1 EMPLOYEE INFORMATION AND VERIFICATION: (To be completed and signed by employee.)

Name: (Print or Type) Last	First	Middle	Birth Name
Address: Street Name and Number	City	State	ZIP Code
Date of Birth (Month/Day/Year)		Social Security Number	

I attest, under penalty of perjury, that I am (check a box):

- ☐ 1. A citizen or national of the United States.
- ☐ 2. An alien lawfully admitted for permanent residence (Alien Number A _____).
- ☐ 3. An alien authorized by the Immigration and Naturalization Service to work in the United States (Alien Number A _____ , or Admission Number _____ , expiration of employment authorization, if any _____).

I attest, under penalty of perjury, the documents that I have presented as evidence of identity and employment eligibility are genuine and relate to me. I am aware that federal law provides for imprisonment and/or fine for any false statements or use of false documents in connection with this certificate.

Signature	Date (Month/Day/Year)

PREPARER/TRANSLATOR CERTIFICATION (To be completed if prepared by person other than the employee). I attest, under penalty of perjury, that the above was prepared by me at the request of the named individual and is based on all information of which I have any knowledge.

Signature	Name (Print or Type)		
Address (Street Name and Number)	City	State	Zip Code

2 EMPLOYER REVIEW AND VERIFICATION: (To be completed and signed by employer.)

Instructions:

Examine one document from List A and check the appropriate box, ***OR*** examine one document from List B ***and*** one from List C and check the appropriate boxes. Provide the ***Document Identification Number*** and ***Expiration Date*** for the document checked.

List A Documents that Establish Identity and Employment Eligibility		List B Documents that Establish Identity	and	List C Documents that Establish Employment Eligibility
☐ 1. United States Passport ☐ 2. Certificate of United States Citizenship ☐ 3. Certificate of Naturalization ☐ 4. Unexpired foreign passport with attached Employment Authorization ☐ 5. Alien Registration Card with photograph		☐ 1. A State-issued driver's license or a State-issued I.D. card with a photograph, or information, including name, sex, date of birth, height, weight, and color of eyes. (Specify State)_____) ☐ 2. U.S. Military Card ☐ 3. Other (Specify document and issuing authority)		☐ 1. Original Social Security Number Card (other than a card stating it is not valid for employment) ☐ 2. A birth certificate issued by State, county, or municipal authority bearing a seal or other certification ☐ 3. Unexpired INS Employment Authorization Specify form #
Document Identification #		***Document Identification*** #		***Document Identification*** #
Expiration Date (if any)		***Expiration Date (if any)***		***Expiration Date (if any)***

CERTIFICATION: I attest, under penalty of perjury, that I have examined the documents presented by the above individual, that they appear to be genuine and to relate to the individual named, and that the individual, to the best of my knowledge, is eligible to work in the United States.

Signature	Name (Print or Type)	Title
Employer Name	Address	Date

Form I-9 (05/07/87)
OMB No 1115-0136

U.S. Department of Justice
Immigration and Naturalization Service

APPENDIX Q (continued)

Employment Eligibility Verification

NOTICE: Authority for collecting the information on this form is in Title 8, United States Code, Section 1324A, which requires employers to verify employment eligibility of individuals on a form approved by the Attorney General. This form will be used to verify the individual's eligibility for employment in the United States. Failure to present this form for inspection to officers of the Immigration and Naturalization Service or Department of Labor within the time period specified by regulation, or improper completion or retention of this form, may be a violation of the above law and may result in a civil money penalty

Section 1. Instructions to Employee/Preparer for completing this form

Instructions for the employee.

All employees, upon being hired, must complete Section 1 of this form. Any person hired after November 6, 1986 must complete this form. (For the purpose of completion of this form the term "hired" applies to those employed, recruited or referred for a fee.)

All employees must print or type their complete name, address, date of birth, and Social Security Number. The block which correctly indicates the employee's immigration status must be checked. If the second block is checked, the employee's Alien Registration Number must be provided. If the third block is checked, the employee's Alien Registration Number *or* Admission Number must be provided, as well as the date of expiration of that status, if it expires.

All employees whose present names differ from birth names, because of marriage or other reasons, must print or type their birth names in the appropriate space of Section 1. Also, employees whose names change after employment verification should report these changes to their employer.

All employees must sign and date the form.

Instructions for the preparer of the form, if not the employee.

If a person assists the employee with completing this form, the preparer must certify the form by signing it and printing or typing his or her complete name and address.

Section 2. Instructions to Employer for completing this form

(For the purpose of completion of this form, the term "employer" applies to employers and those who recruit or refer for a fee.)

Employers must complete this section by examining evidence of identity and employment eligibility, and:

- checking the appropriate box in List A *or* boxes in both Lists B and C;
- recording the document identification number and expiration date (if any);
- recording the type of form if not specifically identified in the list;
- signing the certification section.

NOTE: Employers are responsible for reverifying employment eligibility of employees whose employment eligibility documents carry an expiration date.

Copies of documentation presented by an individual for the purpose of establishing identity and employment eligibility may be copied and retained for the purpose of complying with the requirements of this form and no other purpose. Any copies of documentation made for this purpose should be maintained with this form.

Name changes of employees which occur after preparation of this form should be recorded on the form by lining through the old name, printing the new name and the reason (such as marriage), and dating and initialing the changes. Employers should not attempt to delete or erase the old name in any fashion.

RETENTION OF RECORDS.

The completed form must be retained by the employer for:

- three years after the date of hiring; or
- one year after the date the employment is terminated, whichever is later.

Employers may photocopy or reprint this form as necessary.

U.S. Department of Justice
Immigration and Naturalization Service

OMB #1115-0136
Form I-9 (05-07-87)

APPENDIX R

PERS

Public Employees' Retirement System
Post Office Box 942714
Sacramento, CA 94229-2714
(916) 326-3605

PERS USE ONLY—DOCUMENT REFERENCE NUMBER

HEALTH BENEFITS PLAN ENROLLMENT FORM

PERS—HBD-12 (Rev. 2/88)

▶ PLEASE TYPE ◀

1. TYPE OF ACTION (Check One)
- ☐ a. NEW enrollment
- ☐ b. CHANGE of coverage
- ☐ c. CANCEL all coverage

2. SOCIAL SECURITY NUMBER — —

3. SPOUSE'S SOCIAL SECURITY NUMBER — —

4. Name (FIRST) (MI) (LAST)
No. and Street
City, State, ZIP

5. ☐ Please check if Permanent Intermittent Employee (applies to active State employees only)

6. SEX ☐ Male ☐ Female

7. MARRIED ☐ Yes ☐ No

8. PLAN CODE

9. NAME OF HEALTH PLAN

10. GROSS PREMIUM $

11. FACILITY (if applicable)

12. PRIOR PLAN CODE

13. PRIOR HEALTH PLAN

14. Permitting Event Code

15. Permitting Event Date Mo. Day Year

16. EFFECTIVE DATE Mo. Day Year 01

ACTION CODE	LIST ALL PERSONS (including self) TO BE ENROLLED IN: 17. BASIC PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Family Relationship	CODE
					SELF	

ACTION CODE	18. SUPPLEMENTAL PLAN (FIRST) (MI) (LAST)	DATE OF BIRTH Mo.	Day	Yr.	Relationship	CODE

19. CHECK ONE
- ☐ I **DO NOT** wish to enroll in a Health Benefits Plan under the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to ENROLL IN (OR CHANGE TO) a Health Benefits Plan as shown in Items 8 and 9 above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future. I also certify that the names of all dependents listed above in Items 17 and/or 18 are eligible family members as defined in the Public Employees' Medical and Hospital Care Act.
- ☐ I elect to CANCEL the Health Benefits Plan as shown in Items 12 and 13 above.

20. EMPLOYEE OR ANNUITANT'S SIGNATURE (see privacy information on reverse of employee copy) ▶

21. DATE SIGNED Mo. Day Yr.

▶ PLEASE REFER TO THE HEALTH BENEFITS PROCEDURE MANUAL FOR COMPLETION OF ITEMS 22–27 ◀

22. DEDUCTION PLAN CODE

23. Type of action (Check One) 1. ☐ New 2. ☐ Cancel 3. ☐ Change

24. PAY PERIOD Month Year

25. PARTY CODE

26. EMPLOYEE DESIGNATION

27. BARGAINING UNIT

28. AGENCY NAME (or Retirement System)

29. PAYROLL OFFICE CODE

30. AGENCY CODE

31. UNIT CODE

32. I hereby certify under penalty of perjury as follows:

That I am a duly appointed, qualified and acting officer of the above named agency, and that payment by the agency as provided by Sections 22825–22832 of the Government Code is hereby approved. Final determination of eligibility for the enrollment action specified will be made by the Board of Administration, Public Employees' Retirement System, in accordance with the Public Employees' Medical and Hospital Care Act and the regulations implementing the Act.

SIGNATURE OF HEALTH BENEFITS OFFICER ▶

33. Date received in employing office Mo. Day Yr.

34. PHONE NUMBER ( )

35. REMARKS

WHITE—HBD GREEN—CONTROLLER YELLOW—CARRIER GOLD—PRIOR CARRIER PINK—AGENCY BLUE—EMPLOYEE

APPENDIX S

STATE OF CALIFORNIA

DENTAL PLAN ENROLLMENT AUTHORIZATION

STD 692 (REV 5-87)

D

PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY—SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ACTION (CHECK ONE)
   1. ☐ NEW — ENROLLING IN A PLAN FOR THE FIRST TIME (COMPLETE SECTIONS A, B, AND D)
   2. ☐ CANCEL — CANCELLING COVERAGE FOR ALL ENROLLEES (COMPLETE SECTIONS A, C, AND D)
   3. ☐ CHANGE — CHANGING PLANS OR DEPENDENT COVERAGE (COMPLETE SECTIONS A, B, C, AND D)

2. SOCIAL SECURITY NUMBER

3. MARITAL STATUS ☐ MARRIED ☐ SINGLE

4. SEX ☐ MALE ☐ FEMALE

5. Name in Full (FIRST MIDDLE LAST)

6. Mailing Address (NUMBER AND STREET CITY COUNTY STATE ZIP CODE)

SECTION B (DO NOT COMPLETE THIS SECTION IF THE CANCEL BOX IN SECTION A IS CHECKED)

1. Name of Dental Plan

2. Provider/Facility Number (if applicable)

3. When changing family member enrollment, list all family members currently enrolled, as well as family members to be added and/or deleted. Enter the action code A (add) and/or D (delete) beside the names of *only* those family members to be added or deleted.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN DENTAL PLAN (INCLUDE SELF) (FIRST MIDDLE LAST)	DATE OF BIRTH MO.	DAY	YEAR	FAMILY RELATIONSHIP	ACTION CODE	CONTINUATION OF NAMES OF PERSONS TO BE ENROLLED (FIRST MIDDLE LAST)	DATE OF BIRTH MO.	DAY	YEAR	FAMILY RELATIONSHIP
					SELF						

SECTION C

1. Prior Dental Plan Name

SECTION D

1. CHECK APPROPRIATE BOX

a. ☐ I do not wish to enroll in a dental plan.

b. ☐ I elect to enroll in (or change to) a dental plan as shown above and authorize deductions to be made from my salary or retirement allowance to cover my share of the cost of enrollment as it is now or as it may be in the future.

c. ☐ I elect to cancel the dental plan shown above.

2. EMPLOYEE'S OR ANNUITANT'S SIGNATURE ▶

3. DATE SIGNED

SECTION E (FOR AGENCY OR RETIREMENT SYSTEM USE ONLY)

1. EMPLOYER DED. CODE	2. DENTAL PLAN CODE ORG. CODE	3. EMPLOYEE DEDUCTION AMOUNT	4. PARTY CODE	5. STATE SHARE AMOUNT	6. EFFECTIVE DATE OF ACTION	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
☐ CSU 150 ☐ NON-CSU 100		$		$	-1-			$

COMPLETE ON CANCELLATIONS ONLY

10. PRIOR EMPLOYER DED. CODE	11. PRIOR DENTAL PLAN CODE ORG. CODE	12. PERMITTING EVENT DATE MO. DAY YR.	13. PERMITTING EVENT CODE	14. AGENCY CODE	15. UNIT CODE	16. AGENCY NAME OR RETIREMENT SYSTEM (IF RETIRED)
☐ CSU 150 ☐ NON-CSU 100						

17. REMARKS

18. ☐ CHECK IF PERMANENT INTERMITTENT EMPLOYEE

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows: That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State dental insurance program.

▶

20. TELEPHONE NUMBER (INDICATE IF ATSS OR GIVE AREA CODE)

( )

21. DATE RECEIVED IN EMPLOYING OFFICE MO. DAY YR.

WHITE—To Controller YELLOW—To Carrier PINK—To Agency GREEN—To Employee

88 86127

APPENDIX T

V

STATE OF CALIFORNIA

VISION PLAN ENROLLMENT AUTHORIZATION

STD. 700 REV. 4-87 PLEASE TYPE OR USE BALL POINT PEN, PRINT CLEARLY—SEND COMPLETED FORM TO PERSONNEL/PAYROLL OFFICE

SECTION A SEE PRIVACY NOTICE ON REVERSE OF EMPLOYEE COPY

1. TYPE OF ACTION (CHECK ONE)
   1. ☐ NEW—ENROLLING IN A PLAN FOR THE FIRST TIME (COMPLETE SECTIONS A, B, AND D)
   2. ☐ CANCEL—CANCELLING COVERAGE FOR ALL ENROLLEES (COMPLETE SECTIONS A, C, AND D)
   3. ☐ CHANGE—CHANGING PLANS OR DEPENDENT COVERAGE (COMPLETE SECTIONS A, B, C, AND D)

2. SOCIAL SECURITY NUMBER

3. MARITAL STATUS ☐ MARRIED ☐ SINGLE

4. SEX ☐ MALE ☐ FEMALE

5. Name in Full (FIRST MIDDLE LAST)

6. Mailing Address (NUMBER AND STREET CITY COUNTY STATE ZIP CODE)

SECTION B (DO NOT COMPLETE THIS SECTION IF THE CANCEL BOX IN SECTION A IS CHECKED)

1. Name of Vision Plan

2. Provider/Facility Number (if applicable)

3. When changing family member enrollment, list all family members currently enrolled, as well as family members to be added and/or deleted. Enter the action code A (add) and/or D (delete) beside the names of *only* those family members to be added or deleted.

ACTION CODE	LIST ALL PERSONS TO BE ENROLLED IN VISION PLAN (INCLUDE SELF) (FIRST MIDDLE LAST)	DATE OF BIRTH MO.	DAY	YEAR	FAMILY RELATIONSHIP	ACTION CODE	CONTINUATION OF NAMES OF PERSONS TO BE ENROLLED (FIRST MIDDLE LAST)	DATE OF BIRTH MO.	DAY	YEAR	FAMILY RELATIONSHIP
					SELF						

SECTION C

1. NAME OF VISION PLAN BEING CANCELLED OR CHANGED

SECTION D

1. CHECK APPROPRIATE BOX

a. ☐ I do not wish to enroll in a vision plan.

b. ☐ I elect to enroll in (or change to) a vision plan as shown above and authorize deductions to be made from my salary to cover my share of the cost of enrollment as it is now or as it may be in the future.

c. ☐ I elect to cancel the vision plan shown above.

2. EMPLOYEE'S SIGNATURE ▶

3. DATE SIGNED

SECTION E (FOR AGENCY USE ONLY)

1. EMPLOYER DED. CODE	2. VISION PLAN CODE ORG. CODE	3. PARTY CODE	4. EMPLOYEE DEDUCTION AMOUNT	5. STATE SHARE AMOUNT	6. EFFECTIVE DATE OF ACTION	7. EMPLOYEE DESIGNATION	8. BARGAINING UNIT	9. TOTAL PREMIUM AMOUNT
☐ CSU 450 ☐ NON-CSU 475			$	$	-1-			$

COMPLETE ON CANCELLATIONS ONLY							
10. PRIOR EMPLOYER DED. CODE	11. PRIOR VISION PLAN CODE ORG. CODE	12. PERMITTING EVENT DATE MO. DAY YR.	13. PERMITTING EVENT CODE	14. AGENCY CODE	15. UNIT CODE	16. AGENCY NAME	
☐ CSU 450 ☐ NON-CSU 475							

17. REMARKS

18. ☐ CHECK IF PERMANENT INTERMITTENT EMPLOYEE

19. AUTHORIZED AGENCY SIGNATURE

I hereby certify under penalty of perjury as follows. That I am the duly appointed, qualified and acting officer of the herein named agency and that I am authorized to make this certification; that the employee named herein is eligible for enrollment in the State vision insurance program.

▶

20. TELEPHONE NUMBER (INDICATE IF ATSS OR GIVE AREA CODE)

21. DATE RECEIVED IN EMPLOYING OFFICE MO. DAY YR.

WHITE—TO CONTROLLER CANARY—TO CARRIER PINK TO AGENCY GOLDENROD TO EMPLOYEE

APPENDIX U

State Active Duty
Separation Request

1. Name: _____ SSN: _____

2. Position Title/SAD Grade/Number: _____

3. Employing Activity: _____

4. Reason for Separation:

☐ a. Resignation - - - I resign from my position on State Active Duty effective _____ for the following reasons:

_____ Date: _____
Signature of Employee

_____
Signature of Supervisor

.....

☐ b. Supervisor Initiated Separation - - - I request the above named individual be separated from his State Active Duty position effective _____ for the following reasons:

_____ _____
Supervisor 2d Level Supervisor

Approved: _____ Date: _____
AG/Representative

5. Address to which separation documents and warrants for unpaid compensation should be mailed:

_____

_____

_____

OTAG Form 900-11 (Apr 89)

APPENDIX V

Employee Clearance Form

NAME	POSITION NUMBER	EFFECTIVE DATE OF CLEARANCE
TYPE OF ACTION		
_____ Transfer	_____ Separation	_____ Leave of Absence

Listed below are items that must be cleared prior to the release of final payment to the employee. It is the responsibility of the supervisor to discuss this with the employee, complete the form, and route it to State Personnel with the separation document.

SUPERVISOR

MANUALS/PUBLICATIONS:

_____ Dictionary

EQUIPMENT:

_____ Badge

_____ Tape Recorder

_____ Armory Equipment

_____ Keys, Locks

_____ Other _____

I have reveiwed the records and have determined the above individual is cleared of all state property issued.

_____ _____

SUPERVISOR'S SIGNATURE DATE

COMPTROLLER

ADVANCES:

_____ Salary

_____ Travel

_____ Accounts Receivable

CREDIT CARDS:

_____ Airline

_____ Car Charge Card

_____ Gasoline

_____ Telephone

_____ Other _____

I certify that records indicate there are no outstanding advances or accounts receivables and that all credit cards have been surrendered.

_____ _____

COMPTROLLER'S OFFICE SIGNATURE DATE

PERSONNEL OFFICE USE ONLY

_____ OTAG 900-11
or
_____ STD 687

_____ Accrued Leave

_____ COBRA Eligibility Form

_____ Separation Orders

_____ PERS-ACC-167

REMARKS:

OTAG Form 900-28 (Apr 89) CAL ARNGR 600-1/690-3, CA ANGR 36-10/40-03

APPENDIX W

PLEASE TYPE ALL INFORMATION IF POSSIBLE

State of California EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS	Please complete in triplicate. Retain one copy for your files and mail the original and one copy to **STATE COMPENSATION INSURANCE FUND** *Refer to STATE ADMINISTRATIVE MANUAL, SECTIONS 2581.2 — 2581.5 for instructions on completion and routing* ***BOTH SIDES OF THIS FORM MUST BE COMPLETED***	OSHA Case or File No.

PICA X X X ELITE X X X ← TYPEWRITER ALIGNMENT GUIDE → PICA X X X ELITE X X X

California law requires an employer to report **within five days** every industrial injury or occupational disease which: (a) results in lost time beyond the day of injury, or (b) requires medical treatment other than first aid. **PLEASE NOTE:** In addition, if death results or if the injury or illness: (a) requires inpatient hospitalization of more than 24 hours for other than medical observation; or (b) results in loss of any member of the body; or (c) produces any serious degree of permanent disfigurement, then the nearest district office of the California Division of Occupational Safety and Health also must be notified **immediately** by telephone or telegraph. This notification is not required, however, if the injury or death results from an accident on a public street or highway.

EMPLOYER

1. DEPARTMENT — DIVISION — 1A. P.A.C. OR SCIF POLICY NUMBER
2. MAILING ADDRESS (Number and Street, City, ZIP) — 2A. PHONE NUMBER
3. LOCATION, IF DIFFERENT FROM MAIL ADDRESS (Number and Street, City, ZIP) — 3A. LOCATION CODE
4A. NATURE OF BUSINESS e.g.: painting contractor, wholesale grocer, sawmill, hotel, etc. — 5. STATE UNEMPLOYMENT INSURANCE ACCT. NO.
4B. TYPE OF EMPLOYER: PRIVATE STATE CITY COUNTY SCHOOL DISTRICT OTHER GOVERNMENT — SPECIFY

EMPLOYEE

6. EMPLOYEE NAME — 7. DATE OF BIRTH (MM-DD-YY)
8. HOME ADDRESS (Number and Street, City, ZIP) — 8A. PHONE NUMBER
9. SEX: Male Female — 10. OCCUPATION (Regular job title, not specific activity at time of injury) — 11. SOCIAL SECURITY NUMBER
12. DEPARTMENT IN WHICH REGULARLY EMPLOYED — 12A. DATE OF HIRE (MM-DD-YY)
13. HOURS USUALLY WORKED: HOURS PER DAY — 13A. DAYS PER WEEK — 13B. TOTAL WEEKLY HOURS — 13C. Under what class code of your policy were wages assigned?
14. GROSS WAGES/SALARY: PER: HOUR DAY WEEK TWO WEEKS MONTH OTHER — SPECIFY

INJURY OR ILLNESS

15. WHERE DID ACCIDENT OR EXPOSURE OCCUR? (Number and Street, City) — 15A. COUNTY — 15B. ON EMPLOYER'S PREMISES? YES NO
16. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.)
17. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)
18. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE e.g., the machine employee struck against or which struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin, in cases of strains, the thing he was lifting, pulling, etc.
19A. DESCRIBE THE INJURY OR ILLNESS e.g., cut, strain, fracture, skin rash, etc. — 19B. PART OF BODY AFFECTED e.g. back, left wrist, right eye, etc.
20. NAME AND ADDRESS OF PHYSICIAN (Number and Street, City, ZIP)
21. IF HOSPITALIZED, NAME AND ADDRESS OF HOSPITAL (Number and Street, City, ZIP)
22. DATE OF INJURY OR ILLNESS (MM-DD-YY) — 23. TIME OF DAY: a.m. p.m. — 24. Did employee lose at least one full day's work after the injury? NO YES — Date Last Worked (MM-DD-YY)
25. HAS EMPLOYEE RETURNED TO WORK? No, still off work Yes, date returned: (MM-DD-YY) — 26. DID EMPLOYEE DIE? NO YES — Date of Death (MM-DD-YY)
27. WAS ANOTHER PERSON RESPONSIBLE? NO YES — 28. PERS/STRS MEMBER NO YES — 29. ARE LEAVE CREDITS AVAILABLE TO BE USED IN SUPPLEMENTING TEMPORARY DISABILITY BENEFITS? NO YES

Completed by (type or print)	Signature	Title	Date

PLEASE DO NOT USE THIS COLUMN
CASE NO.
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
ACCIDENT TYPE
A.O.S.
EXTENT OF INJURY
CODED BY

SCIF 3067 STATE (REV. 4-87) **FILING OF THIS REPORT IS NOT AN ADMISSION OF LIABILITY. NOTICE OF WORKERS' COMPENSATION BENEFITS MUST BE GIVEN TO INJURED WORKER WITHIN 5 DAYS OF YOUR KNOWLEDGE OF THIS INJURY.** FORM 5020 (REV. 5-April 1987)

APPENDIX W (continued)

If the Supervisor and Manager Review portions of this form cannot be completed within five days of the injury, DO NOT DELAY SUBMISSION OF THE REVERSE SIDE TO STATE FUND. Submit the form completed in its entirety to the Departmental Safety Coordinator within ten days of the injury.

EMPLOYEE'S NAME	UNIT	SOCIAL SECURITY NUMBER

SUPERVISOR'S REVIEW

Facts available lead me to believe this work injury was caused by and happened during State work ☐	From the facts I need my superior's or a physician's advice. The alleged claim of injury is not clearly identified with State employment ☐	The facts do not indicate this claim of injury was work connected ☐

GIVE THE FACTS THAT JUSTIFY THE ITEMS CHECKED:

WHAT CORRECTIVE ACTION IS BEING TAKEN TO PREVENT SIMILAR ACCIDENTS? HAVE YOU TAKEN THESE STEPS? ☐ YES ☐ NO If no explain

I DO NOT HAVE AUTHORITY TO TAKE THE FOLLOWING ACTION BUT RECOMMEND:

IF INJURED EMPLOYEE IS UNABLE TO PERFORM FULL DUTY:

A. THE POSSIBILITY OF MODIFIED WORK WAS DISCUSSED WITH THE ATTENDING DOCTOR: ☐ YES ☐ NO

B. MODIFIED WORK DECISION: ☐ Condition precludes M.W. ☐ Appropriate M.W. not available ☐ M.W. arranged ..... days

Signature	Classification	Date

MANAGER'S REVIEW

DO YOU CONCUR WITH 1ST LINE SUPERVISOR'S REVIEW? ☐ YES ☐ NO If no, explain

Signature and Date

CONTINUATION AND MISCELLANEOUS COMMENTS

STATE COMPENSATION INSURANCE FUND ADJUSTING OFFICES

P.O. BOX 915
ARCADIA, CALIFORNIA 91006

P.O. BOX 9729
BAKERSFIELD, CALIFORNIA 93389

P.O. BOX 6165
CERRITOS, CALIFORNIA 90701

P.O. BOX 2518
CULVER CITY, CALIFORNIA 90230

P.O. BOX 4973
EUREKA, CALIFORNIA 95502

P.O. BOX 40000
FRESNO, CALIFORNIA 93755

P.O. BOX 2134, TERMINAL ANNEX
LOS ANGELES, CALIFORNIA 90051

P.O. BOX 12971
OAKLAND, CALIFORNIA 94604

P.O. BOX 2377
REDDING, CALIFORNIA 96099

P.O. BOX 254700
SACRAMENTO, CALIFORNIA 95865

P.O. BOX 1316
SAN BERNARDINO, CALIFORNIA 92402

P.O. BOX 85488
SAN DIEGO, CALIFORNIA 92138

P.O. BOX 807
SAN FRANCISCO, CALIFORNIA 94101

P.O. BOX 759
SAN JOSE, CALIFORNIA 95106

P.O. BOX 419
SANTA ANA, CALIFORNIA 92702

P.O. BOX 2407
SANTA ROSA, CALIFORNIA 95405

P.O. BOX 8000
STOCKTON, CALIFORNIA 95208

P.O. BOX "S"
VENTURA, CALIFORNIA 93002

P.O. BOX 1950
WOODLAND HILLS, CALIFORNIA 91365

APPENDIX X

STATE OF CALIFORNIA

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	UNIT TELEPHONE NO

UNEMPLOYMENT INSURANCE CLAIM RECORD

UNIT, POSITION, AND SERIAL NUMBER	DATE LAST WORKED

REASON - CHECK ONE

☐ LACK OF WORK ☐ MAXIMUM 1500 HOURS WORKED ☐ END OF TEMPORARY APPOINTMENT

☐ OTHER - EXPLAIN _____

I CONCUR WITH THE REASON CHECKED ABOVE

SIGNATURE OF EMPLOYEE	DATE
▶	

STD 600 (8/62)

APPENDIX Y

STATE OF CALIFORNIA

UNEMPLOYMENT COMPENSATION NOTICE

STD 660 (NEW 11/82)

This form has been given to you because (1) you have been separated from your job, or (2) you were placed in a nonpay status.

When unemployed, State workers may be entitled to Unemployment Insurance (UI) benefits similar to those of workers in private industry. If you become unemployed or are in a nonpay status and want to FILE A CLAIM, go to the nearest LOCAL OFFICE of the EMPLOYMENT DEVELOPMENT DEPARTMENT to register for work and file your claim for UI. Your ELIGIBILITY FOR UI CANNOT be determined until AFTER you file a claim. DO NOT DELAY filing a UI claim; if you wait, your unemployment benefits may be reduced or you may not qualify for any benefits.

TAKE WITH YOU—

1. Your SOCIAL SECURITY ACCOUNT NUMBER CARD. (If you do not have a card, apply for one, but you do not need to delay filing your claim pending its receipt.)
2. THIS FORM and all similar forms which you have received. The office where you file your claim will obtain information needed for your claim from:

State agency will insert in the box above the name of the State agency address and ZIP Code of the specific office that should receive notice of your claim as required by law.

KEEP THIS FORM with your other personnel records. It is important to have it if you file a UI claim. For more information about UI, read the REVERSE side of this form.

Information: UI For State Workers

1. Who will pay unemployment benefits?

If you are eligible, you will be paid by the Employment Development Department (EDD) under the provisions of California Unemployment Insurance Code. The amount of your regular weekly benefits and the period for which benefits will be paid will be determined by EDD based on the wages you were paid during a one-year period beginning 16–18 months before the date your claim is filed. (If you have received all the regular benefits for which you are eligible, you may under certain circumstances, become eligible for additional weeks of extended benefits.)

UI for unemployed State workers is paid from State funds. No deductions were taken from your pay to finance these benefits.

2. Under what conditions will I be eligible?

a. You must be unemployed or working less than full time, able to work and available for any suitable work;
b. You must register for work and file a claim at a local public employment service/UI claim office;
You must continue to report to the office as directed; and
c. You must have had a certain amount of employment/wages within a base period of 1 year specified in the law.

You may be denied benefits for such reasons as:

a. Quitting your job voluntarily without good cause or being discharged for misconduct connected with your work; or
b. Refusing an offer of a suitable job without good cause.

3. Do I have the right of appeal?

a. Yes. If a determination is made denying you benefits, you have the right to appeal. You or the employer have 20 calendar days to appeal in writing after written notice is given.

4. Are there any penalties?

a. Yes. If you willfully make a false (fraudulent) claim, you may be fined or imprisoned, or both. If you made a mistake in giving information when you filed your claim(s), notify the local UI claims office as soon as you discover the mistake; prompt notification may avoid a penalty.

(The above statements are issued for general information; they do not have the effect of law, regulation, or ruling.)

STD 660 (New 11/82)

27553-750 9-82 68M ©D OSP 1178

REPORT OF DUTY—STATE ACTIVE DUTY PERSONNEL

NAME: _____

SSN: _____

LOCATION: _____

FROM: _____ **TO:** _____

CODE

D - DUTY STATUS
A - ORDINARY LEAVE STATUS
*M - MILITARY LEAVE STATUS
W - LEAVE WITHOUT PAY STATUS
**S - SICK LEAVE STATUS
J - JURY DUTY
PH - PERSONAL HOLIDAY

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
ENTER DUTY DAYS																															
ENTER OTHER THAN DUTY DAYS																															

I certify that the attendances and absences recorded above are correct and that all leave was approved in accordance with existing laws and regulations and that there has been no change in my dependency status for the period concerned.

REMARKS:

_____
(EMPLOYEE SIGNATURE)

_____
(COMMANDER/SUPERVISOR SIGNATURE)

* Include military orders
** Include OCG Form 600-1

OCG Form 900-16 (Mar 82)