Gravette School District

609 Birmingham St. SE Gravette, AR 72736 / 479-787-4100

Complete ALL three (3) sections of this checklist

Section 1:

Checklist of Forms Required to Complete

_____ Office Record

_____ Federal Tax W-4

_____ State Tax AR4EC

_____ Direct Deposit

_____ Teacher Retirement Enrollment

_____ Verification of Prior Employment
-Employee is responsibly for completing & sending to previous employers

_____ AR Benefits Enrollment
-Complete & signed eve if you are declining coverage
-Dependents will need copy of birth certificate or social security card. Spouses will need copy of marriage license

_____ Colonial Life Enrollment
-Complete & signed evening if declining coverage

Optional Benefits

_____ Delta Dental / Vision Enrollment

_____ HSA Application
-HSA is an option ONLY if enrolling in ARBenefits Basic Coverage

Additional Required Documentation

_____ Teaching License (Certified Staff Only)

_____ Official / Unofficial Transcript

_____ Supporting Licensure Documentation or Certification (if applicable)

_____ Bring 2 forms of government issued ID with you when you turn in this packet. (ex. driver's license & social security card)

Section 2:

Background check & Fingerprinting

_____ Once you have completed all of the new hire paperwork, please immediately follow the steps outlined on the attached Background Check / Fingerprint Instruction page. Pursuant to Ark. Code Ann. § 6-17-414, these screenings must be initiated promptly to comply with mandatory state educational employment standards. Additionally, All employees must renew this process at intervals not to exceed five (5) years, or upon every licensure renewal, whichever occurs first.

Section 3:

I-9 Employment Eligibility Verification *(This will be completed during fingerprinting at the Admin office)*

_____ By federal law, this verification must be processed by one of the district's designated representatives once you submit your completed packet to the Administration Office. You will be asked to present original, unexpired documentation proving your identity and employment authorization to be briefly examined and photocopied, and you must sign Section 1 of the I-9 Form in person.

For more information about the law for I-9 verification and to view the complete list of acceptable documents, please visit the U.S. Citizenship and Immigration Services (USCIS) website at www.uscis.gov/i-9-central or consult the federal statute under the Immigration Reform and Control Act of 1986 (8 U.S.C. § 1324a).

If you have any questions, or need assistance, please contact Personnel Services:
Arissa Blakeslee / email: arissa.blakeslee@gravetteschools.net / phone 479-787-4100



Payroll Office Record

Complete All Blanks

Name:_____DOB_____

Street Address:_____

City/State:_____Zip:_____

Social Security Number:_____

Name as it appears on your Social Security Card:_____

Home Phone Number:_____Alternate Number:_____

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

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

2026

Step 1: Enter Personal Information

(a) First name and middle initial	Last name	(b) Social security number

Address

City or town, state, and ZIP code

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*.

(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.)

Caution: To claim certain credits or deductions on your tax return, you (and/or your spouse if married filing jointly) are required to have a social security number valid for employment. See page 2 for more information.

TIP: Consider using the estimator at *www.irs.gov/W4App* to determine the most accurate withholding for the rest of the year if you: are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

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 the 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 Step 2(b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, Step 2(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):

(a) Multiply the number of qualifying children under age 17 by $2,200 . . . . . **3(a)** $

(b) Multiply the number of other dependents by $500 . . . **3(b)** $

Add the amounts from Steps 3(a) and 3(b), plus the amount for other credits. Enter the total here . . . . . **3** $

Step 4: 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. Use the Deductions Worksheet on page 4 to determine the amount of deductions you may claim, which will reduce your withholding. (If you skip this line, your withholding will be based on the standard deduction.) Enter the result here . . **4(b)** $

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

Exempt from withholding

I claim exemption from withholding for 2026, and I certify that I meet **both** of the conditions for exemption for 2026. See *Exemption from withholding* on page 2. I understand I will need to submit a new Form W-4 for 2027 . ☐

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.

X _____ _____

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)
Gravette Public Schools 609 Birmingham St SE Gravette, AR 72736		71-6021336

General Instructions

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

Future Developments

For the latest information about developments related to Form W-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 2026 if you meet both of the following conditions: you had no federal income tax liability in 2025 **and** you expect to have no federal income tax liability in 2026. You had no federal income tax liability in 2025 if (1) your total tax on line 24 on your 2025 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 28, 29, and 30), 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 2026 tax return. To claim exemption from withholding, certify that you meet both of the conditions by checking the box in the *Exempt from withholding* section. 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 16, 2027.

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. Are submitting this form after the beginning of the year;

2. Expect to work only part of the year;

3. Have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), or number of dependents, or changes in your deductions or credits;

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

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

TIP: Have your most recent pay stub(s) from this year available when using the estimator to account for federal income tax that has already been withheld this year. At the beginning of next year, use the estimator again to recheck your withholding.

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. Submit a separate Form W-4 for each job.

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 of tax withheld 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 (and/or your spouse if married filing jointly) must have the required social security number to claim certain credits. 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.

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 15, if you expect to claim deductions other than the basic standard deduction on your 2026 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for qualified tips, overtime compensation, and passenger vehicle loan interest; student loan interest; IRAs; and seniors. You (and/or your spouse if married filing jointly) must have the required social security number to claim certain deductions. For additional eligibility requirements, see Pub. 501.

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 when you file your tax return.

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 5. 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 5 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 5 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 (plus any other additional amount you want withheld) . . . . . **4** $

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

See the Instructions for Schedule 1-A (Form 1040) for more information about whether you qualify for the deductions on lines 1a, 1b, 1c, 3a, and 3b.

1 Deductions for qualified tips, overtime compensation, and passenger vehicle loan interest.

- **a** **Qualified tips.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified tips up to $25,000 . . . . . **1a** $
- **b** **Qualified overtime compensation.** If your total income is less than $150,000 ($300,000 if married filing jointly), enter an estimate of your qualified overtime compensation up to $12,500 ($25,000 if married filing jointly) of the "and-a-half" portion of time-and-a-half compensation . . . . . **1b** $
- **c** **Qualified passenger vehicle loan interest.** If your total income is less than $100,000 ($200,000 if married filing jointly), enter an estimate of your qualified passenger vehicle loan interest up to $10,000 **1c** $

2 Add lines 1a, 1b, and 1c. Enter the result here . . . . . **2** $

3 **Seniors age 65 or older.** If your total income is less than $75,000 ($150,000 if married filing jointly):

- **a** Enter $6,000 if you are age 65 or older before the end of the year . . . . . **3a** $
- **b** Enter $6,000 if your spouse is age 65 or older before the end of the year and has a social security number valid for employment . . . . . **3b** $

4 Add lines 3a and 3b. Enter the result here . . . . . **4** $

5 Enter an estimate of your student loan interest, deductible IRA contributions, educator expenses, alimony paid, and certain other adjustments from Schedule 1 (Form 1040), Part II. See Pub. 505 for more information . . . . . **5** $

6 **Itemized deductions.** Enter an estimate of your 2026 itemized deductions from Schedule A (Form 1040). Such deductions may include qualifying:

- **a** **Medical and dental expenses.** Enter expenses in excess of 7.5% (0.075) of your total income . **6a** $
- **b** **State and local taxes.** If your total income is less than $505,000 ($252,500 if married filing separately), enter state and local taxes paid up to $40,400 ($20,200 if married filing separately) . **6b** $
- **c** **Home mortgage interest.** If your home acquisition debt is less than $750,000 ($375,000 if married filing separately), enter your home mortgage interest expense (including mortgage insurance premiums) . . . . . **6c** $
- **d** **Gifts to charities.** Enter contributions in excess of 0.5% (0.005) of your total income . . . . **6d** $
- **e** **Other itemized deductions.** Enter the amount for other itemized deductions . . . . . **6e** $

7 Add lines 6a, 6b, 6c, 6d, and 6e. Enter the result here . . . . . **7** $

8 **Limitation on itemized deductions.**

- **a** Enter your total income . . . . . **8a** $
- **b** Subtract line 4 from line 8a. If line 4 is greater than line 8a, enter -0- here and on line 10. Skip line 9 **8b** $

9 Enter:
- $768,700 if you're married filing jointly or a qualifying surviving spouse
- $640,600 if you're single or head of household
- $384,350 if you're married filing separately

. . . . . **9** $

10 If line 9 is greater than line 8b, enter the amount from line 7. Otherwise, multiply line 7 by 94% (0.94) and enter the result here . . . . . **10** $

11 **Standard deduction.**

Enter:
- $32,200 if you're married filing jointly or a qualifying surviving spouse
- $24,150 if you're head of household
- $16,100 if you're single or married filing separately

. . . . . **11** $

12 **Cash gifts to charities.** If you take the standard deduction, enter cash contributions up to $1,000 ($2,000 if married filing jointly) . . . . . **12** $

13 Add lines 11 and 12. Enter the result here . . . . . **13** $

14 If line 10 is greater than line 13, subtract line 11 from line 10 and enter the result here. If line 13 is greater than line 10, enter the amount from line 12 . . . . . **14** $

15 Add lines 2, 4, 5, and 14. Enter the result here and in Step 4(b) of Form W-4 . . . . . **15** $

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	$480	$850	$850	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020
$10,000 - 19,999	0	480	1,480	1,850	2,050	2,220	2,220	2,220	2,220	2,220	2,220	2,620
$20,000 - 29,999	480	1,480	2,480	3,050	3,250	3,420	3,420	3,420	3,420	3,420	3,820	4,820
$30,000 - 39,999	850	1,850	3,050	3,620	3,820	3,990	3,990	3,990	3,990	4,390	5,390	6,390
$40,000 - 49,999	850	2,050	3,250	3,820	4,020	4,190	4,190	4,190	4,590	5,590	6,590	7,590
$50,000 - 59,999	1,020	2,220	3,420	3,990	4,190	4,360	4,360	4,760	5,760	6,760	7,760	8,760
$60,000 - 69,999	1,020	2,220	3,420	3,990	4,190	4,360	4,760	5,760	6,760	7,760	8,760	9,760
$70,000 - 79,999	1,020	2,220	3,420	3,990	4,190	4,760	5,760	6,760	7,760	8,760	9,760	10,760
$80,000 - 99,999	1,020	2,220	3,420	4,240	5,440	6,610	7,610	8,610	9,610	10,610	11,610	12,610
$100,000 - 149,999	1,870	4,070	6,270	7,840	9,040	10,210	11,210	12,210	13,210	14,210	15,360	16,560
$150,000 - 239,999	1,870	4,100	6,500	8,270	9,670	11,040	12,240	13,440	14,640	15,840	17,040	18,240
$240,000 - 319,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,780	14,980	16,180	17,380	18,580
$320,000 - 364,999	2,040	4,440	6,840	8,610	10,010	11,380	12,580	13,860	15,860	17,860	19,860	21,860
$365,000 - 524,999	2,720	5,920	9,390	12,260	14,760	17,230	19,530	21,830	24,130	26,430	28,730	31,030
$525,000 and over	3,140	6,840	10,540	13,610	16,310	18,980	21,480	23,980	26,480	28,980	31,480	33,990

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	$90	$850	$1,020	$1,020	$1,020	$1,070	$1,870	$1,870	$1,870	$1,870	$1,870	$1,970
$10,000 - 19,999	850	1,780	1,980	1,980	2,030	3,030	3,830	3,830	3,830	3,830	3,930	4,130
$20,000 - 29,999	1,020	1,980	2,180	2,230	3,230	4,230	5,030	5,030	5,030	5,130	5,330	5,530
$30,000 - 39,999	1,020	1,980	2,230	3,230	4,230	5,230	6,030	6,030	6,130	6,330	6,530	6,730
$40,000 - 59,999	1,020	2,880	4,080	5,080	6,080	7,080	7,950	8,150	8,350	8,550	8,750	8,950
$60,000 - 79,999	1,870	3,830	5,030	6,030	7,100	8,300	9,300	9,500	9,700	9,900	10,100	10,300
$80,000 - 99,999	1,870	3,830	5,100	6,300	7,500	8,700	9,700	9,900	10,100	10,300	10,500	10,700
$100,000 - 124,999	2,030	4,190	5,590	6,790	7,990	9,190	10,190	10,390	10,590	10,940	11,940	12,940
$125,000 - 149,999	2,040	4,200	5,600	6,800	8,000	9,200	10,200	10,950	11,950	12,950	13,950	14,950
$150,000 - 174,999	2,040	4,200	5,600	6,800	8,150	10,150	11,950	12,950	13,950	14,950	16,170	17,470
$175,000 - 199,999	2,040	4,200	6,150	8,150	10,150	12,150	13,950	15,020	16,320	17,620	18,920	20,220
$200,000 - 249,999	2,720	5,680	7,880	10,140	12,440	14,740	16,840	18,140	19,440	20,740	22,040	23,340
$250,000 - 449,999	2,970	6,230	8,730	11,030	13,330	15,630	17,730	19,030	20,330	21,630	22,930	24,240
$450,000 and over	3,140	6,600	9,300	11,800	14,300	16,800	19,100	20,600	22,100	23,600	25,100	26,610

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	$280	$850	$950	$1,020	$1,020	$1,020	$1,020	$1,560	$1,870	$1,870	$1,870
$10,000 - 19,999	280	1,280	1,950	2,150	2,220	2,220	2,220	2,760	3,760	4,070	4,070	4,210
$20,000 - 29,999	850	1,950	2,720	2,920	2,980	2,980	3,520	4,520	5,520	5,830	5,980	6,180
$30,000 - 39,999	950	2,150	2,920	3,120	3,180	3,720	4,720	5,720	6,720	7,180	7,380	7,580
$40,000 - 59,999	1,020	2,220	2,980	3,570	4,640	5,640	6,640	7,750	8,950	9,460	9,660	9,860
$60,000 - 79,999	1,020	2,610	4,370	5,570	6,640	7,750	8,950	10,150	11,350	11,860	12,060	12,260
$80,000 - 99,999	1,870	4,070	5,830	7,150	8,410	9,610	10,810	12,010	13,210	13,720	13,920	14,120
$100,000 - 124,999	1,870	4,270	6,230	7,630	8,900	10,100	11,300	12,500	13,700	14,210	14,720	15,720
$125,000 - 149,999	2,040	4,440	6,400	7,800	9,070	10,270	11,470	12,670	14,580	15,890	16,890	17,890
$150,000 - 174,999	2,040	4,440	6,400	7,800	9,070	10,580	12,580	14,580	16,580	17,890	18,890	20,170
$175,000 - 199,999	2,040	4,440	6,400	8,510	10,580	12,580	14,580	16,580	18,710	20,320	21,620	22,920
$200,000 - 249,999	2,720	5,920	8,680	10,900	13,270	15,570	17,870	20,170	22,470	24,080	25,380	26,680
$250,000 - 449,999	2,970	6,470	9,540	12,040	14,410	16,710	19,010	21,310	23,610	25,220	26,520	27,820
$450,000 and over	3,140	6,840	10,110	12,810	15,380	17,880	20,380	22,880	25,380	27,190	28,690	30,190

AR4EC

STATE OF ARKANSAS
Employee's Withholding Exemption Certificate

Print Full Name _____ Social Security Number _____

Print Home Address _____ City _____ State _____ Zip _____

Employee:
File this form with your employer. Otherwise, your employer must withhold state income tax from your wages without exemptions or dependents.

Employer:
Keep this certificate with your records.

How to Claim Your Withholding
See instructions below

	Number of Exemptions Claimed
1. CHECK ONE OF THE FOLLOWING FOR EXEMPTIONS CLAIMED	
a. ☐ You claim yourself. *(Enter one exemption)* 1a	
b. ☐ You claim yourself and your spouse. *(Enter two exemptions)* 1b	
c. ☐ Head of Household, and you claim yourself. *(Enter two exemptions)* 1c	
2. NUMBER OF CHILDREN or DEPENDENTS. *(Enter one exemption per dependent)* 2	
3. TOTAL EXEMPTIONS. *(Add Lines 1a, b, c, and 2)* If no exemptions or dependents are claimed, enter zero 3	
4. Additional amount, if any, you want deducted from each paycheck. *(Enter dollar amount)* 4	
5. I qualify for the low-income tax rates. *(See below for details)* ..... 5 Please check filing status: ☐ Single ☐ Married Filing Jointly ☐ Head of Household	☐ Yes ☐ No

I certify that the number of exemptions and dependents claimed on this certificate does not exceed the number to which I am entitled.

Signature: X _____ Date: _____

Employee must sign. Not valid until signed.

Instructions

TYPES OF INCOME - This form can be used for withholding on all types of income, including pensions and annuities.

NUMBER OF EXEMPTIONS – *(Husband and/or Wife)* Do not claim more than the correct number of exemptions. However, if you expect to owe more income tax for the year, you may increase your withholding by claiming a smaller number of exemptions and/or dependents, or you may enter into an agreement with your employer to have additional amounts withheld. This is especially important if you have more than one employer, or if both husband and wife are employed.

DEPENDENTS – To qualify as your dependent *(line 2 of form)*, a person must *(a)* receive more than 1/2 of their support from you for the year, *(b)* not be claimed as a dependent by such person's spouse, *(c)* be a citizen or resident of the United States, and *(d)* have your home as their principal residence and be a member of your household for the entire year or be related to you as follows: son, daughter, grandchild, stepson, stepdaughter, son-in-law or daughter-in-law; your father, mother, grandparent, stepfather, stepmother, father-in-law or mother-in-law; your brother, sister, stepbrother, stepsister, half-brother, half-sister, brother-in-law or sister-in-law; your uncle, aunt, nephew or niece *(but only if related by blood)*.

CHANGES IN EXEMPTIONS OR DEPENDENTS – You may file a new certificate at any time if the number of exemptions or dependents INCREASES. You must file a new certificate within 10 days if the number of exemptions or dependents previously claimed by you DECREASES for any of the following reasons:

(a) Your spouse for whom you have been claiming an exemption is divorced or legally separated from you, or claims his or her own exemption on a separate certificate, **or**

(b) The support you provide to a dependent for whom you claimed an exemption is expected to be less than half of the total support for the year.

OTHER DECREASES in exemptions or dependents, such as the death of a spouse or a dependent, does not affect your withholding until next year, but requires the filing of a new certificate by December 1 of the year in which they occur.

You may claim additional amounts of withholding tax if desired. This will apply most often when you have income other than wages.

You qualify for the low income tax rates if your **total** income from all sources is:

(a) Single	$12,493	to	$14,900
(b) Married Filing Jointly (1 or less dependents)	$21,068	to	$24,800
(c) Married Filing Jointly (2 or more dependents)	$25,356	to	$30,800
(d) Head of Household/Qualifying Widow(er) (1 or less dependents)	$17,762	to	$21,600
(e) Head of Household/Qualifying Widow(er) (2 or more dependents)	$21,173	to	$24,800

For additional information consult your employer or write to:

Arkansas Withholding Tax Section
P. O. Box 8055
Little Rock, Arkansas 72203-8055

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 05/31/2027

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. An alien 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)
X	

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)
Blakeslee, Arissa - Personnel Services, HR		

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Gravette Public Schools	609 Birmingham St. SE Gravette, AR 72736

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, sex, 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, sex, 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.
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**8.** Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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.

Supplement A,
Preparer and/or Translator Certification for Section 1

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

USCIS
Form I-9
Supplement A
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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

Signature of Preparer or Translator			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

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

Additional Information (Initial and date each notation.)

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

Direct Deposit Authorization

Employee Name:_____

Mailing Address:_____

_____

Bank Name: _____

Account Type: _____Checking _____Savings

Routing Number: _____

Account Number: _____

I hereby authorize the Gravette School District to have my salary deposited directly to the financial institute named above. I also authorize Gravette School District to initiate debit entries to my account in the event that a credit entry is to be found incorrect.

Employee Signature: x_____

Date: _____

ARTRS
Arkansas Teacher Retirement System

Form # 5
1400 West Third
Little Rock, AR 72201
Phone (501) 682-1517
Fax (501) 682-2359
www.artrs.gov

Irrevocable Contributory Election Form

PLEASE READ THOROUGHLY. This election form to participate in the Arkansas Teacher Retirement System (ATRS) contributory plan is to be completed by both the member and employer. *Once received by ATRS this becomes a binding and **irrevocable** election to participate in the contributory plan.* Under the contributory plan deductions are withheld from the member's salary for retirement purposes.

This election form is to be utilized by the following (please check one):

_____ Non-contributory member who is electing to become a contributory member, must make an election by June 30 to become effective July 1. Status may be also changed to contributory if the election is made prior to their first salary payment of the fiscal year. Elections made after the first salary payment of the fiscal year shall become effective the July 1 next following receipt of this form in the ATRS office. The official receipt date may be determined by the postmark date.

_____ New member under contract for 184 days or less who is electing to become contributory.

_____ New member not under contract who is electing to become contributory.

Once signed by both the member and employer and received by ATRS, this election to be contributory is IRREVOCABLE. This means the undersigned member's election cannot be changed under any circumstances and will remain in effect throughout the member's entire career with ATRS.

I have read and understand the above material and I elect **TO MAKE CONTRIBUTIONS TO THE RETIREMENT SYSTEM for the remainder of my career.**

THIS FORM IS NOT OFFICIAL UNLESS SIGNED BY BOTH THE MEMBER AND EMPLOYER AND RECEIVED BY ATRS.

I. To be completed by Member:

Social Security Number _____
Print Member's Name _____
Signed by (Member's Name) _____
Address _____
City, State, Zip _____
Date _____

II. To be completed by Employer:

Signed by (Employer Representative) _____
Employer _____
First Salary Payment this fiscal year (date) _____
Fiscal Year Effective (xxxx-yyyy) _____

Return original completed form to ATRS; the employer and member should each keep a copy.

Gravette School District
609 Birmingham St. SE Gravette, AR 72736
Phone 479-787-4100 ~ Fax 479-974-1066 ~ kim.skaggs@gravetteschools.net

Verification of Prior Employment

To Whom it may concern:

I have been hired by the Gravette School District. Since my salary will be determined by my years of verified teaching experience, I would appreciate you completing Part II below and forwarding it within five (5) business days to the Payroll Dept.

Gravette School District - Payroll Dept.
ATTN: Kim Skaggs
609 Birmingham St. SE
Gravette, AR 72736

_____
Employee Signature

Part I - Personal Data (to be completed by employee & sent to prior entities)

Name_____ SS#:_____
Last First MI Maiden/Other

If more than one (1) prior school district, please duplicate this form for each district.

Prior School District	Mailing Address/Fax/Email	Position Held	Dates of Employment
_____	_____	_____	_____

Part II - Employment Record/Teaching Experience (to be completed by the appropriate school official)

****Sick days can be transferred from Arkansas schools ONLY****

Employment Dates (Beginning-Ending)	Sick Leave (Balance)	FT or PT/Days Worked (Contracted Days)	Position/Subject/Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signed _____ Title _____
(school official)

School System/Employer _____ Date _____

Address _____ Phone/Fax_____

Email _____

AR BENEFITS

ARKANSAS STATE EMPLOYEES
ACTIVE MONTHLY RATES

RATES EFFECTIVE JANUARY 1, 2026 – DECEMBER 31, 2026

Plan	Base Monthly Premium	State & Plan Contribution	Employee Total Monthly Cost	Per -Payroll Deduction
PREMIUM				
Employee Only	$621.60	$469.80	$151.80	$75.90
Employee & Spouse	$1,554.00	$1,101.52	$452.48	$226.24
Employee & Child(ren)	$1,181.04	$870.48	$310.56	$155.28
Employee & Family	$2,113.42	$1,519.40	$594.32	$297.16
CLASSIC				
Employee Only	$540.41	$467.99	$72.42	$36.21
Employee & Spouse	$1,351.02	$1,092.34	$258.68	$129.34
Employee & Child(ren)	$1,026.77	$862.15	$164.62	$82.31
Employee & Family	$1,837.38	$1503.40	$333.98	$166.99
BASIC				
Employee Only	$476.96	$476.96	$0.00	$0.00
Employee & Spouse	$1,192.41	$1,087.21	$105.20	$52.60
Employee & Child(ren)	$906.23	$856.95	$49.28	$24.64
Employee & Family	$1,621.66	$1,494.02	$127.64	$63.82
The Basic Plan meets the minimum essential coverage required under A.C.A.				

State Contribution is funded by legislation.
Plan Contribution is funded by ASE Trust Fund as Claims Reserve Allocation.

AR BENEFITS

Below is a snapshot of benefits covered by the ARBenefits plan for each of our 2026 Public School Employee plan levels. A full schedule of benefits for each plan level is available HERE. If you have any questions, please contact EBD at 877-815-1017 or email Ask.EBD@arkansas.gov.

	PREMIUM		CLASSIC		BASIC
	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK
INDIVIDUAL DEDUCTIBLE	$750	$2,000	$1,750	$3,000	$4,000
FAMILY DEDUCTIBLE	$1,500	$4,000	$3,400/$3,500	$6,000	$8,000
INDIVIDUAL OUT-OF-POCKET MAX (MEDICAL)	$3,250	N/A	$6,450	N/A	$6,450
FAMILY OUT-OF-POCKET MAX (MEDICAL)	$6,500	N/A	$9,675	N/A	$12,900
	YOU PAY		YOU PAY		YOU PAY
COVERED SERVICES	IN-NETWORK	OUT OF NETWORK	IN-NETWORK	OUT OF NETWORK	IN-NETWORK
PHYSICIAN'S OFFICE VISIT	$25 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
SPECIALIST'S OFFICE VISIT	$50 COPAY	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
OTHER PHYSICIAN SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
ADVANCED IMAGING (RADIOLOGY)	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
ER VIST AND OBSERVATION	$250 COPAY	$250 COPAY	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
IN-PATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
OUTPATIENT HOSPITAL SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
DIAGNOSTIC SERVICES	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
URGENT CARE CENTER	$100 COPAY	$100 COPAY	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
PHYSICAL EXAMS/PREVENTATIVE CARE	0%	0%	0%	0%	0%
IMMUNIZATIONS	0%	0%	0%	0%	0%
WELL BABY/CHILD CARE VISITS	0%	40% AFTER DEDUCTIBLE	0%	40% AFTER DEDUCTIBLE	0%
VISION SCREENING	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY
HEARING SCREENING	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY	$50 COPAY
INSULIN PUMP	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
GLUCOMETERS	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE	40% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE

- Members must meet their plan's deductible amount before coinsurance begins for covered services.
- The family deductible is the deductible amount for any tier above Employee Only coverage (Employee + Spouse, Employee + Children, Family).
- Copays do not count towards the deductible amount. The out-of-pocket maximum includes the deductible, copays, and coinsurance amounts you have paid toward covered in-network services.
- Employees on the ***Premium Plan*** can have the $250 ER copay waived if they are referred to the ER by the Nurse24 hotline (1-866-458-0408). The Nurse24 hotline is not intended for use during medical emergencies.
- The plan will pay 100% for individuals on family coverage when they reach the individual out-of-pocket maximum amount.
- There is no out-of-network coverage for the Basic Plan.

PRESCRIPTION DRUGS	PREMIUM	CLASSIC	BASIC
TIER 1 - GENERIC	$15 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
TIER 2 - PREFERRED	$40 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
TIER 3 - NON-PREFERRED	$80 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
TIER 4 - SPECIALTY	$100 COPAY	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
REFERENCED PRICE DRUGS	PLAN PAYS CERTAIN AMOUNTS PER UNIT; MEMBER RESPONSIBLE FOR REMAINING COST	NOT COVERED	NOT COVERED
INDIVIDUAL RX OUT-OF-POCKET MAX	$3,100	N/A	N/A
FAMILY RX OUT-OF-POCKET MAX	$6,200	N/A	N/A

Employees on the Classic or Basic plans must meet their plan medial deductible amounts prior to starting the 20% coinsurance for covered medications.

2026 Rates (per month)

Premium

Employee Only: $201.96
Employee & Spouse: $706.92
Employee & Child(ren): $457.28
Employee & Family: $779.68

Classic

Employee Only: $88.38
Employee & Spouse: $347.76
Employee & Child(ren): $209.30
Employee & Family: $391.88

Basic

Employee Only: $43.24
Employee & Spouse: $241.58
Employee & Child(ren): $140.02
Employee & Family: $262.12

2026 Open Enrollment



Open Enrollment for the 2026 plan year is October 1-31, 2025. You can enroll online through the ARBenefits Member Portal at my.ARBenefits.org. Changes elected during Open Enrollment are effective 1/1/2026. If you do not want to make any changes to your ARBenefits medical health plan, you do NOT need to re-enroll. Your current coverage will stay as is for 2026.

If you have an FSA, you MUST re-enroll each year.

Visit our website at www.sas.arkansas.gov for more information.

Things you can do during Open Enrollment

- Enroll in an ARBenefits Plan
- Change plans between Premium, Classic, Basic
- Drop/add dependents
- Cancel your coverage for the next year

State & Public-School Employee Election Form

This form is to be used for Open Enrollment and New Enrollees ONLY. Please use the Change Form for other Qualifying Events.

Employee Information

First Name	MI	Last Name	Date of Birth	Gender ☐ M ☐ F	Social Security Number

Agency or District	Group Number	Home/Cell Number ☐ preferred	Work Number ☐ preferred
Gravette School District	*040404*		

Mailing Address	City	State	Zip Code

Physical Address

Coverage

Enrollment Period:
☐ Open Enrollment ☐ Loss of other coverage
☐ New Hire Period
☐ Newborn

Type of Action:
☐ Enroll in the Plan
☐ Decline Coverage

If enrolling, pick a benefit option:
☐ Premium ☐ Basic
☐ Classic

Post-Tax Election:
☐ **ONLY** check this box if you wish to have your premiums withheld on a **post-tax** basis

If Declining, Reason for Decline: ☐ Enrolling in Spouse's Plan (complete 1 and 1a below) ☐ Not Interested (skip to signature at bottom)

1. Is spouse an AR State or Public School Employee? ☐ Yes (proceed to signature) ☐ No (complete fields below)

Spouse First Name:	MI:	Spouse Last Name:	Suffix:	Spouse Date of Birth:

1a. Spouse SSN or ITIN:	Spouse's Employer:

Add/Drop Dependents

Please check the correct column to ADD a dependent to the plan or DROP a dependent currently covered. Proof of a dependent's eligibility must be submitted with this application for all dependents.

ADD	DROP	NAME (FIRST, MI, LAST)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	MALE	FEMALE	RELATIONSHIP
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	
☐	☐				☐	☐	

Subscriber Certification

I authorize deductions of the required contributions (if applicable). I understand that my elections can only be changed during the next open enrollment period or if I have a qualifying event as defined in the ARBenefits Summary Plan Description. I understand I must request such changes within 60 days of the qualifying event. On behalf of myself and anyone enrolled on or added to this form, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the heath plan/insurer, for any administrative purpose, including evaluation of an application or claim. I also authorize on behalf of health plan/insurer the use of a Social Security Number for the purpose of identification. A photocopy of this authorization will be as valid as the original. Please note that falsifying documents, misrepresenting dependent status or using other fraudulent actions to gain coverage may be criminal acts and can lead to permanent termination of coverage. I understand by signing the election form, it means I have read and agree with the attached instruction page and understand the options I chose on the election form.

Employee Signature	Date	Preferred Email

FOR PSE HIR USE ONLY First Day at Work:

SUBMISSION TO EMPLOYEE BENEFITS DIVISION IS FINAL

Department of Shared Administrative Services • Employee Benefits Division
P.O. Box 15610 • Little Rock, AR 72231-5610 • Fax: 501-683-0983

Coverage is effective 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

Instructions

ALL PORTIONS OF THE ELECTION FORM MUST BE COMPLETED OR IT WILL BE SENT BACK FOR COMPLETION PRIOR TO PROCESSING.

Social Security Numbers are required for enrollment. Exception: A newborn's Social Security Number will be accepted after enrollment but must be sent in once it is received.

You must drop all of your ineligible dependents. When your dependents no longer meet eligibility requirements, their coverage ends the last day of the month they became ineligible. You may be responsible for any cost for services received by any dependent(s) while your dependent(s) was incorrectly listed as eligible.

If you experience a qualifying event that allows you to cancel your health insurance, you can only enroll again during the next annual open enrollment period or if you have a qualifying status change event. Qualifying status change events include marriage, birth, and loss of group coverage.

You should receive ID cards in a timely manner from the Employee Benefits Division (EBD). If you do not, call EBD at 1-877-815-1017 (when you hear the recording, press 1).

Your effective date of coverage will be the first of the month following date of EBD receiving application and **ALL** corresponding documentation. Note: The qualifying date is NOT the date of eligibility.

Pre-tax premiums increase your take-home pay because your insurance premiums will be deducted from your salary before taxes are calculated. You will automatically be in a pre-tax status unless you select the post-tax option on this form and/or notify your payroll clerk.

Active members who turn age 65 or become eligible for Medicare must send in a copy of their Medicare card to EBD.

Supporting documentation is required for proof of dependent eligibility. For changes being made due to a qualifying event, documented proof a qualifying event has occurred is also required such as a Certificate of Credible Coverage (COCC). More information is available in the ARBenefits Summary Plan Description.

If adding a dependent as a Permanent Legal Guardian your account will be subject to an annual review.

If a Member is currently not enrolled on the plan and has a newborn, only **ONE** parent is permitted to enroll with the newborn.

Competed election forms can be submitted to EBD by fax, mail, or online through the ARBenefits Member Portal at www.myarbenefits.org.

For assistance, contact EBD at 1-877-815-1017 Monday - Friday, from 8:00AM - 4:00PM CST or email Ask.EBD@arkansas.gov. To learn more about plans, costs, and network providers visit https://sas.arkansas.gov/employee-benefits.

SUBMISSION TO EMPLOYEE BENEFITS DIVISION IS FINAL.

Coverage is effective 1st of the month and termed at the end of the month following date of receipt and based on eligibility rules.

Affidavit of Spousal Healthcare Coverage

Employee Name		Employee SSN	
Spouse Name		Spouse SSN	

To be completed by employee electing to enroll a spouse in coverage.

Pursuant to Arkansas Code Ann. §21-5-407(4), any spouse who is offered coverage for Medical Benefits under any other employer-sponsored health plan is NOT eligible to be covered under the ARBenefits Plan.

1. Is your spouse currently employed?

   ☐ Yes (If yes, please proceed to question #2)

   ☐ No (If no, sign and return this form along with your election form and a copy of your marriage license)

2. Is your spouse currently employed by an Arkansas state agency or public school district?

   ☐ Yes (If yes, sign and return this form along with your election form and a copy of your marriage license)

   ☐ No (If no, proceed to question #3)

3. Is your spouse eligible for his/her employer-sponsored group health plan?

   ☐ Yes

   ☐ No (If no, please submit information from your spouse's employer as to why your spouse is not covered)

For any questions or concerns, contact EBD at 1-877-815-1017 x1 or email Ask.EBD@arkansas.gov

By signing this affidavit I certify that the information provided above is accurate. I understand that any misrepresentations in the information I provided above will permit the ARBenefits Plan to terminate my coverage. If applicable, I authorize the release of the information noted above and agree to its use in the application process for ARBenefits Plan coverage.

Employee signature: _____ Date: _____

Spouse signature: _____ Date: _____

MAIL OR FAX FORM AND ACCOMPANYING DOCUMENTS TO:
Department of Transformation and Shared Services - Employee Benefits Division
PO Box 15610, Little Rock, AR 72231-5610 - FAX: 501-683-0983

HSA Application and Salary Reduction Agreement

This Salary Reduction Agreement (SRA) authorizes your employer to reduce your salary by the indicated amount shown below for the exclusive purpose of facilitating a contribution to your Health Savings Account. Do not send contributions with this form. By completing this agreement, you are indicating that as of the effective date of your contribution election, you are an "Eligible Individual" as defined in the adoption agreement and authorize your employer to facilitate your monthly contributions to your HSA on your behalf.

Please fill out the form below and return to your HR office.

Are you a current HSA account holder?

☐ Yes Fill out only your Name in Section 1 and proceed to Sections 2 through 5.
☐ No Complete ALL information and sign the form. Look in the mail for your HSA Welcome Letter, which includes additional HSA services.

Section 1: Account Holder Information (Please Print)

Name (First, MI, Last)_____

Preferred Mailing Address ☐ Home Address ☐ Mailing Address (if different)

Home Address _____ Mailing Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Email Address _____

Preferred Phone Number ☐ Home ☐ Work Best Time to Call _____ ☐ AM ☐ PM

Home Phone (___) _____ Work Phone (___) _____

Date of Birth _____ Social Security Number _____

Driver's License Number _____ Mother's Maiden Name (Security) _____

Employer _____

Section 2: Primary Beneficiary

Name (First, MI, Last) _____

Address _____ City _____ State _____ Zip _____

Social Security Number _____ Relationship _____

If all individuals listed as Primary Beneficiaries precede you in death or cannot be located after a reasonable search by the custodian, all non-allocated funds (if any) in your account will be distributed to your Contingent Beneficiary (to add/edit/change Contingent Beneficiary(ies), log in to your account). In the event that no beneficiary can be located, your account balance (if any) will be distributed to your estate.

Section 3: HDHP Information and HSA Contribution Election

HDHP Coverage Effective Date _____ Check one ☐ Single Coverage ☐ Family Coverage

I elect a monthly contribution of $ _____ (amount) to my HSA effective _____ (date).

Section 4: Debit Card

☐ I hereby request a debit card as an alternate distribution method from my HSA account. (See Article IV of the Custodial Account Agreement for terms of usage.) Print exactly as you would like it to appear on your card: 21 characters maximum including spaces. If more than two cards are needed, attach a separate sheet.

Name on 1st Card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name on 2nd Card ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section 5: Adoption Agreement/Employee Signature

As of the effective date of my HSA Contribution Election, I certify that I am an "Eligible Individual" as defined by the Code and do hereby elect a Health Savings Account in accordance with Section 223 and Section 125 of the Internal Revenue Code. I understand this request will not be processed until all paperwork is completed, accepted and approved by my employer. I further understand that I am responsible for all contributions made to my HSA and that my benefits administrator is facilitating but not initiating the contribution. If the account is closed at any time, there will be a $25 closing fee.

This application is for the establishment of my individually owned Health Savings Account at the custodian displayed below. The information on this application is true and accurate to the best of my knowledge and I submit this form with full understanding and acceptance of the provisions contained within the Custodial Account Agreement, HSA Terms and Conditions Statement, and the HSA Disclosure Statement. I also acknowledge that the Plan Service Provider (PSP) indicated on the bottom of this form is authorized to perform transactions on my account and all such transactions initiated by the PSP should be treated as if initiated directly by me, the Account Holder. I am currently, or will be upon the date of my first contribution, an Eligible Individual as described in the Custodial Account Agreement. I understand that maintaining my eligibility is my responsibility and that the custodian will assume that all contributions are made while I am eligible to do so. I am currently, or will be upon the date of my contribution, covered by a High Deductible Health Plan (HDHP) that meets the qualifications detailed in the Custodial Account Agreement.

_____ _____

Signature of Account Holder Date

Custodian
DataPath Financial Services
PO Box 55068
Little Rock, AR 72215

Plan Service Provider
Beneliance
Serial No. 666576474227

PO Box 55068 | Little Rock, AR 72215
501-687-6954 | Toll-free: 877-685-0655 | Fax: 855-445-1696
Beneliance.com | benefits@beneliance.com

Gravette School District

609 Birmingham Street SE , Gravette, Arkansas 72736
479-787-4100 | www.gravetteschools.net

Jeff Gravette,
Superintendent of Schools
609 Birmingham Street SE

Rebecca Andrews, *Assistant Superintendent of Schools*
609 Birmingham Street SE.

Dr. Brandi Newsom, *Principal*
Glenn A. Duffy Elementary
601 El Paso Street SE

Dr. Mandy Barrett, *Principal*
Gravette Upper Elementary
500 8th Ave SE

Taos Jones, *Principal*
Gravette Middle School
607 Dallas St SE

Cory Briggs, *Assistant Principal*
Gravette Middle School
607 Dallas St SE

Fran Howard, Principal
Gravette High School
325 Lion Drive S.

Bryan Bearden, *Assistant Principal*
Gravette High School
325 Lion Drive S.

Andrew Vire,
Director of Athletics
325 Lion Drive S.

Courtney Malott, *Director of Special Education*
601 El Paso Street SE

Richard Carver, *Director of Transportation & Maintenance*
1133 Main St SE

Sheila Roughton,
Director of Food Services
406 6th Avenue SE

Daniel Rice,
Director of Technology
406 6th Avenue SE

Delta Dental of Arkansas

Dental & Vision Insurance
http://www.deltadentalar.com

Rates effective January 1, 2026 through December 31, 2026

Delta Dental Rates

Subscriber Only - $32.48
Subscriber + Spouse - $62.33
Subscriber + Children - $59.35
Subscriber + Spouse + Children- $112.88

Delta Vision Rates

Subscriber Only- $10.28
Subscriber + Spouse- $18.99
Subscriber + Children- $20.55
Subscriber + Spouse + Children- $28.80

DELTA DENTAL

ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
E-mail: eligibility@deltadentalar.com
Fax (501) 992-1890

☐ New Enrollment ☐ Status Change ☐ Address Change ☐ Termination

☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date

Month	Day	Year

Group Number: GA918903

Group Name: Gravette

Social Security Number

Subscriber's Identifier (if applicable)

LAST NAME: _____ FIRST: _____ MI: ____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMAIL: _____

Date of Birth / / MM DD YY

Marital Status ☐ Single ☐ Married

Sex ☐ Male ☐ Female

Date of Hire / / MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code."

Enter P for pregnant, D for diabetes, and H for Heart Disease)

☐ Pregnancy - Expected due date _____

☐ Diabetes - Date of onset _____

☐ Heart Disease - Date of onset _____

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

Dental
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

Vision
☐ Employee
☐ Employee/Spouse
☐ Employee/Child
☐ Employee/Children
☐ Employee/Family

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change
☐ Late Entrance (employee)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other _____

☐ COBRA effective date _____

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Date of event _____
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student

_____

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time**.
☐ I authorize payroll deductions.

Signature: X _____ Date: _____

Colonial Life®

Group Term Life Insurance with Accidental Death & Dismemberment (AD&D) Insurance for Active Employees



How secure is your family's financial future without you?

If something happened to you, would your family be able to maintain their way of life? How would they cover ongoing living expenses? Colonial Life's group term life insurance can help provide financial security for your family.

There are two convenient options to enroll:

1. Enroll with a telephonic Colonial Life benefits counselor.

Ask benefits questions and complete your enrollment by calling:

833-703-1967, Employer Code: 8038317 | Monday-Friday | 7 a.m. to 7 p.m. CT

Benefit confirmation forms can be emailed to you at the conclusion of the enrollment.

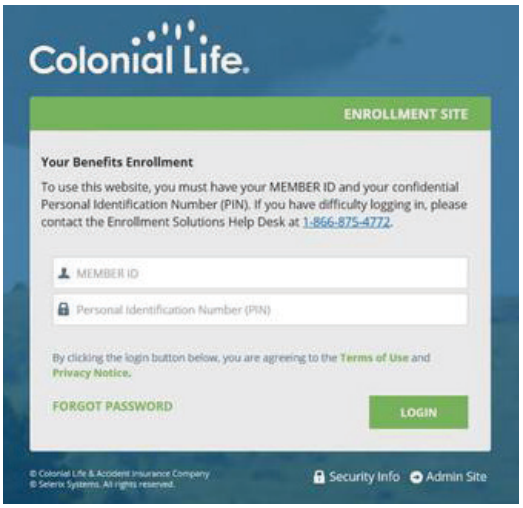
2. Self-enroll online.

Scan the QR Code or access the enrollment site URL directly at Harmony.benselect.com/SoA

Use the following login information:

- **Log In: MEMBER ID (This is also your Health ID number.)**
- **Personal Identification Number: The last four digits of your Social Security number and the last two digits of your birth year (six digits total)**

During your online enrollment, you will be prompted to accept or decline each coverage type, premiums will be displayed for your selections and the appropriate health questions will be displayed, when applicable. Benefit confirmation forms can be printed or saved at the conclusion of the enrollment.



Enrollment opportunities:

1. During annual enrollment
2. 60-day new hire eligibility period
3. Within 60 days of a qualifying event, such as marriage, birth or adoption

Employees who are eligible for ARBenefits health insurance are also eligible for Group Term Life with AD&D insurance. Employees should allow a minimum of 7 business days from their new hire date before accessing the enrollment site or the telephonic enrollment. This will allow time for employees' eligibility data to be uploaded into the enrollment platform.

Your basic and optional coverages

Coverage options	Who pays	Benefit amount(s)	
Basic group term life with AD&D insurance	Employer	**$10,000**	Your employer is providing this benefit, and you will be automatically enrolled.
Expanded basic group term life with AD&D insurance	Employee	**$1,000** increments up to **$40,000**	Health questions are not asked during the 2024 Plan Year Open Enrollment and new hire enrollment.
Supplemental employee group term life with AD&D insurance	Employee	**$1,000** increments up to **$250,000**	Health questions are not asked during the 2024 Plan Year Open Enrollment and new hire enrollment for benefit amounts up to $100,000. Any benefit amount over $100,000 is subject to evidence of insurability.
***Supplemental spouse group term life with AD&D insurance**	Employee	**$1,000** increments up to **$50,000**	Health questions are not asked during the 2024 Plan Year Open Enrollment and new hire enrollment for spouse benefit amounts up to $10,000. Any benefit amount over $10,000 is subject to evidence of insurability.
***Supplemental dependent child(ren) group term life with AD&D insurance**	Employee	**$1,000** increments up to **$50,000**	Health questions are not asked during the 2024 Plan Year Open Enrollment and new hire enrollment for spouse and coverage up to $10,000. Any benefit amount over $10,000 is subject to evidence of insurability.

** Employee must elect supplemental group term life with AD&D insurance on themselves in order to elect supplemental group term life with AD&D insurance for the spouse or dependent child(ren). Effective 1/1/2020, the spouse and/or child supplemental group term life with AD&D benefit amount must be either equal to or lower than the employee's supplemental group term life with AD&D benefit amount.*

2024 Rates (per $1,000) Monthly cost of coverage

Expanded basic group term life with AD&D insurance

$0.31 per $1,000

Supplemental group term life with AD&D insurance

Age	Employee
Under 25	$0.12
25-29	$0.12
30-34	$0.15
35-39	$0.16
40-44	$0.25
45-49	$0.41
50-54	$0.66
55-59	$0.95
60-64	$1.43
65-69	$2.78
70-74	$ 4.53
75+	$ 9.03

Supplemental spouse group term life with AD&D insurance

All eligible ages	$0.86

Supplemental dependent child(ren) group term life with AD&D insurance

All eligible ages	$0.12

A person may only be insured once under this plan. Married employees eligible for ARBenefits life insurance may not be insured both as an employee and as a spouse, and a child may only be insured by one employee.

EXCLUSIONS AND LIMITATIONS

Losses Not Covered Under Your Life Insurance Benefit:

Your life insurance benefit does not cover any losses where death is caused by, contributed to by, or results from suicide occurring within 24 months after a covered person's initial effective date of insurance or after the date any increases or additional insurance becomes effective, whether sane or insane.

This applies to any amounts of insurance for which you pay all or part of the premium.

This applies to any amount subject to evidence of insurability requirements and we approve the evidence of insurability form and the amount you applied for at that time.

You will be given credit for any period of time applied toward the satisfaction of the suicide provision, if any, under your Employer's prior group life insurance plan.

Losses Not Covered Under the AD&D Insurance Benefit:

Your AD&D benefit does not cover any losses that are caused by, contributed to by, or resulting from:

- an attempt to commit or commission of suicide or intentional self-inflicted injury while sane or insane;
- active participation in a riot;
- an attempt to commit or commission of a felony or engaging in an illegal occupation;
- voluntary use of any drugs, poisonous substance, intoxicant or narcotic, except any drugs taken as prescribed by a physician and taken as prescribed. Accidental exposure to any poisonous substance will not be excluded;
- the presence of that percentage of alcohol in the covered person's blood which raises a presumption that the covered person was under the influence of alcohol. The blood-alcohol level which raises this presumption is governed by the laws of the state in which the accident occurred;
- disease of the body, mental infirmity or diagnostic, medical or surgical treatment;
- being exposed to war or any act of war, declared or undeclared, or serving in the armed forces of any country or authority. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release; or
- investigational or experimental procedures, surgery, or drugs, including complications arising from having experimental or investigative procedures, surgeries, or drugs.

Termination

Coverage terminates:

- if the group policy ends;
- the date you no longer meet eligibility requirements;
- the end of the grace period if we do not receive the required premium for your insurance; or
- the date the next premium is due after you ask us to end your coverage.

If you are no longer eligible for coverage as an active employee, you may be eligible to port your group term life and AD&D coverage, or you may convert your group term life and AD&D coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

Evidence of Insurability means a statement of medical history which we will use to determine if an applicant is approved for coverage. Blood profiles and medical examinations, if applicable, will be provided at our expense. Evidence of Insurability is required for any amount of life insurance over the maximum guaranteed issue amount.

Premium will vary based on plan options and face amount selected.

The effective date of your coverage will be delayed if you are not a member of an eligible class on the coverage effective date. The coverage will be effective on the date that you return to status as a member of an eligible class. If the certificate covers your spouse and/or dependent children, their coverage will be effective on the date that you return to status as a member of an eligible class.

Applicable to policy number GTL1.0-P-AR-SOA and certificate number GTL1.0-C-AR-SOA. This is not an insurance contract and only the actual policy provisions will control.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC
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COLONIAL LIFE & ACCIDENT INSURANCE COMPANY, PO BOX 1365, COLUMBIA, SC 29202
STATE OF ARKANSAS PUBLIC SCHOOL EMPLOYEES - GROUP TERM WITH AD&D INSURANCE ENROLLMENT FORM

District Name: Gravette School District			**District Code:** 040404
SECTION 1: EMPLOYEE INFORMATION – Always complete			
Proposed Insured Name (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street City State Zip Code			Member ID No.
Email Address		Primary Phone No. Secondary Phone No.	
Date Employed	Actively Employed by: AR Public School		Annual Salary

SECTION 2: SPOUSE/DEPENDENT CHILDREN INFORMATION – Complete only if applying for spouse and/or dependent children coverage				
Spouse Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			
Are there any eligible dependent children applying for coverage?				☐Yes ☐ No

SECTION 3: GUARANTEED ISSUE COVERAGE INFORMATION – Always complete
(For any amount over the maximum benefit shown below, you must complete Evidence of Insurability form.) ***Administrative use only**

Coverage Type	**Tax Status**	**Coverage Amount**	***Plan Code**	***Monthly Premium**
☐ Basic Group Term Life with AD&D ($10,000)	[redacted]	$10,000	8F1B	$ 2.00
☐ Expanded Basic Group Term Life with AD&D ($1,000 increments, up to $40,000)	Pre-Tax ☐ Post Tax ☐	$	8F1E	$
☐ Supplemental Group Life with AD&D ($1,000 increments, up to $100,000)	Post Tax	$	8F1S	$
☐ Spouse Supplemental Group Term Life with AD&D ($1,000 increments, up to $10,000)	Post Tax	$	8SP1	$
☐ Dependent Child(ren) Supplemental Group Term Life with AD&D ($1,000 increments, up to $10,000)	Post Tax	$	4CH1	$
☐ I do not wish to participate/continue the State of Arkansas Public School Employee (PSE) Group Tern Life with AD&D Plan. I understand that if I enroll later, I must provide evidence of insurability.			**Total Premium $**	

SECTION 4: BENEFICIARY INFORMATION – for the employee benefit only					
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

AGREEMENT SECTION

THE PROPOSED INSURED AGREES AS FOLLOWS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. I have read this form and the answers and statements above are true and complete to the best of my knowledge and belief. I understand that this form will not be binding upon Colonial Life & Accident Insurance Company (Colonial Life) until both: 1) the certificate is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial Life's only obligation will be to refund all premiums paid. I understand that the statements and answers in this form are the basis for any certificate issued by Colonial Life, and no information about me will be considered to have been given to Colonial Life unless it is stated in the form.

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If I have elected to pay my premiums for Colonial Life & Accident Insurance Company's Group Term Life insurance with pre-tax dollars, I am aware of the tax savings I receive through a flexible benefits plan. While the Internal Revenue Service (IRS) allows me to receive tax savings on my premiums, the IRS also may require me to pay taxes on insurance benefits I receive from coverage purchased through a flexible benefits plan.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices.

Signed at: City_____ State _____ Date _____
mm/dd/yyyy

(x)_____