

Employee's Withholding Certificate

OMB No. 1545-0074

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.

2026

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) ☐ Single or Married filing separately ☐ Married filing jointly or Qualifying surviving spouse ☐ Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		
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 <i>Exemption from withholding</i> 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.		
	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)



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)				

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)		Additional Information		
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)				
☐ 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)	
Beddow, Elisabeth					
Employer's Business or Organization Name		Employer's Business or Organization Address, City or Town, State, ZIP Code			
Pauls Valley Public Schools		P.O. Box 780, Pauls Valley, OK 73075			

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

PAULS VALLEY PUBLIC SCHOOLS
PO BOX 780
PAULS VALLEY, OK 73075
405/238-6453

TO: All Employees

FROM: Elisabeth Beddow -- Payroll Clerk

SUBJECT: Direct Deposit

All employees of Pauls Valley Public Schools will have their paychecks direct deposited. This includes any final payment owed to you after your termination date. Please complete this form:

1. Sign the authorization at the bottom of this page.
2. Attach a voided check.
3. Return to me.

Thank you for your cooperation.

Date _____

I, _____ give Pauls Valley Public Schools authorization to have my pay check direct deposited into my account.



IMPORTANT! Read the Plan Guidelines (Page 3) before completing this form.

Employer information (to be completed by insurance coordinator)

Group ID 254018	Division ID A238	Group name PAULS VALLEY PUBLIC SCHOOLS
☐ New hire enrollment		☐ Midyear enrollment

Employee information

Name (First MI Last)		SSN
Date of birth	☐ Male ☐ Female	☐ Married ☐ Single
Mailing address		City State ZIP code
Phone	Alt phone	Email
Effective date of coverage (MM/01/YYYY)		Alt email

Health plan election

☐ BCBSOK BlueLincs HMO	☐ HealthChoice High
☐ CommunityCare HMO	☐ HealthChoice Basic
☐ GlobalHealth HMO	☐ HealthChoice High Deductible Health Plan (HDHP)
Employee primary physician (HMO only)	☐ Current patient ☐ New patient

Dental plan election

☐ BCBSOK BlueCare Dental High Plan	☐ Delta Dental PPO
☐ BCBSOK BlueCare Dental Low Plan	☐ HealthChoice
☐ Cigna Prepaid High Dental Care Plan	☐ MetLife High Classic MAC
☐ Cigna Prepaid Low Dental Care Plan	☐ MetLife Low Classic MAC
☐ Delta Dental PPO – Choice	☐ Sun Life Preferred Active PPO
Employee primary dentist (Prepaid only)	☐ Current patient ☐ New patient

Vision plan election

☐ Primary Vision Care Services (PVCS)	☐ Vision Care Direct
☐ Superior Vision	☐ VSP (Vision Service Plan)

Life plan election

Basic and Supplemental Life can be added only during initial enrollment, Option Period, or within 30 days of the loss of other group life insurance (must provide proof). **Guaranteed Issue Supplemental Life** (two times your annual salary rounded to the next \$20,000 unit) is only available to new hires. To request more than your GI amount, a life insurance application is required for approval. The maximum amount of Supplemental Life available is \$500,000.

☐ Basic Life (required for enrollment in Supplemental Life)	\$
☐ Supplemental Life (in \$20,000 units)	\$
Total Basic and Supplemental Life insurance requested:	\$0

Dependent Life

☐ Premier Option (spouse = \$20,000, each child = \$10,000)
☐ Standard Option (spouse = \$10,000, each child = \$5,000)
☐ Low Option (spouse = \$6,000, each child = \$3,000)

FOR EGID USE ONLY

Disability plan election (available only to certain county employees)

☐ HealthChoice Disability

Dependent information

Spouse name		☐ Health ☐ Dental	☐ Vision ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	
Does your spouse have coverage through EGID? ☐ Yes ☐ No (If yes, list name and SSN above.)			
Child name		☐ Health ☐ Dental	☐ Vision ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	
Child name		☐ Health ☐ Dental	☐ Vision ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	
Child name		☐ Health ☐ Dental	☐ Vision ☐ Dependent Life
SSN		Primary physician ☐ Current patient ☐ New patient	
Date of birth	☐ Male ☐ Female	Primary dentist ☐ Current patient ☐ New patient	

To list additional dependents, please obtain the Dependent Attachment Form from your insurance coordinator.

Signatures

I certify all selections made on this form are true and in compliance with the Plan Guidelines for Insurance Enrollment. I agree to deliver documentation that authenticates this statement to EGID upon request.

Employee signature	Date
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Spouse must sign if common-law or excluded from health, dental and/or vision coverage.

☐ **Common-law spouse certification:** I certify that this person listed above as my spouse and I have an actual and mutual agreement between ourselves to be married; this is a permanent relationship, and our relationship is exclusive, as proven by our cohabitation as spouses; and do hereby hold ourselves out publicly as married. I am aware that this relationship can be dissolved only by legal divorce.

☐ **Spouse exclusion certification (only required if children are covered and spouse is not):** I certify that I am aware I am being excluded from health, dental and/or vision coverage as indicated on this form. I am also aware that an employee who elects to cover all eligible dependent children and not their spouse will not have the opportunity to enroll their spouse until the next annual Option Period or when a change of status event occurs.

Spouse signature	Date
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I certify this enrollment is in compliance with the provisions of the employer's Section 125 Plan or, if no 125 Plan is offered, is in compliance with new hire or allowed midyear coverage enrollments as defined by 26 U.S. Code § 125 of the Internal Revenue Code (as amended) and pertinent regulations. I further certify that on this date, this employee's annual salary listed below (if required) is correct to the best of my knowledge.

Employee's annual salary (required for Supplemental Life more than \$20,000)	
Insurance coordinator signature	Date



Introduction

You are receiving this notice because you have recently become covered under a group health, dental and/or vision plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage through EGID. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered through EGID when they would otherwise lose their group coverage. For additional information about your rights and obligations through EGID and under federal law, you should review your plan handbook or contact EGID.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the health insurance marketplace. By enrolling in coverage through the marketplace, you may qualify for lower monthly premiums and out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible, such as a spouse's plan, even if that plan generally does not accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of coverage when coverage would otherwise end because of a life event known as a qualifying event. Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your spouse and your dependent children could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage through EGID because of these qualifying events:

- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee (or former employee), you will become a qualified beneficiary if you lose your coverage through EGID because of these qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than gross misconduct.
- Your spouse (former employee) becomes entitled to Medicare benefits (Part A, Part B or both).
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage because of these qualifying events:

- You die.
- Your hours of employment are reduced.
- Your employment ends for any reason other than gross misconduct.
- You become entitled to Medicare benefits (Part A, Part B or both).
- You and your spouse divorce or legally separate.
- The child stops being eligible for coverage under the plan as a dependent child.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered through EGID, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage.

When is COBRA continuation coverage available?

EGID will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified in writing that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, the commencement of a proceeding in bankruptcy with respect to the employer, or you become entitled to Medicare benefits (Part A, Part B or both), the employer must notify EGID of the qualifying event.

You must give notice of some qualifying events.

For all other qualifying events (divorce or legal separation of you and your spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify EGID within 30 days after the qualifying event occurs. You must provide this notice to the insurance/benefits coordinator at your employing agency. The notification must be in writing; a telephone call is not sufficient. You may also be required to provide documentation or other required information.

How is COBRA continuation coverage provided?

Once EGID receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have a right to elect independent COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events or a second qualifying event during the initial period of coverage may permit a beneficiary to receive a maximum of 36 months of coverage. There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered by EGID is determined by the Social Security Administration to be disabled and you notify EGID within 60 days of the SSA determination and before the end of the first 18 months of continuation coverage, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

A copy of the Social Security disability determination must be sent to EGID, P.O. Box 11137, Oklahoma City, OK 73136-9998 before the expiration of the 18 months of COBRA, and within 60 days from the later of:

1. The date of the Social Security Administration disability determination.
2. The date of the qualifying event.
3. The loss of coverage date.
4. The date the qualified beneficiary is informed of the obligation to provide the disability notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to EGID. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die, become entitled to Medicare benefits (Part A, Part B or both), get divorced or legally separated, or if the dependent child stops being eligible as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage through EGID had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the health insurance marketplace, Medicaid or other group health plan coverage options such as a spouse's plan through what is called a special enrollment period. Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [HealthCare.gov](https://www.healthcare.gov).

If you have questions

Questions concerning your coverage or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act, including COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration in your area or visit [DOL.gov/ebsa](https://www.dol.gov/ebsa). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website. For more information about the marketplace, visit [HealthCare.gov](https://www.healthcare.gov).

Keep your plan informed of address changes

To protect your family's rights, keep EGID informed of any changes in the addresses of family members. You should also keep a copy of any notices you send to EGID.

Plan contact information

Please contact the insurance coordinator at your employer. If you have additional questions about COBRA, send written questions to OMES EGID, Attention: Member Services, P.O. Box 11137, Oklahoma City, OK 73136-9998; or call 405-717-8780 or toll-free 800-752-9475. TTY users call 711. You can also visit the website at [Oklahoma.gov/omes](https://www.oklahoma.gov/omes), and in the menu under Services, select Employees Group Insurance Division.

I have been provided with and have read the General Notice of Cobra Continuation Coverage Rights by Pauls Valley Public Schools.

Employee Signature_____

Spouse Signature_____

Date_____



Employees Group Insurance Division Beneficiary Designation Form

MEMBER INFORMATION

SSN or Member ID: _____ Member name: _____
First MI Last

Address: _____
☐ New address Street City State ZIP

Phone: (____) _____ Alt Phone: (____) _____

Important: Please ensure the Share percentage in both Primary Beneficiary(ies) and Contingent Beneficiary(ies) add up to 100%. Payment will be made in equal shares to all surviving beneficiaries unless otherwise indicated.

PRIMARY BENEFICIARY(IES)

Primary beneficiary's name and address	SSN	Phone	Relationship	Date of birth	Share percentage
					100%

CONTINGENT BENEFICIARY(IES)

Proceeds are paid to the contingent beneficiary(ies) identified below only if there is no surviving primary beneficiary(ies).

Contingent beneficiary's name and address	SSN	Phone	Relationship	Date of birth	Share percentage
					100%

I have named the above beneficiary(ies) to receive my life insurance benefits from HealthChoice. I understand this form replaces and cancels all prior beneficiary designations and will become effective only when it is received by EGID.

Member signature (original signature required)

Date

Mail this form to EGID at P.O. Box 11137, Oklahoma City, OK 73136-9998



**TRS NONCLASSIFIED OPTIONAL
EMPLOYEE PARTICIPATION OPT-OUT**

IMPORTANT: Please read instructions on page 2 before completing form.

SECTION ONE – to be completed by employee. Please complete ALL sections.

Employee's First, Middle, Last Name

Employee's SSN

Employee's Telephone

Employee's Date of Birth

Employee's Position

Have you **ever** been a member of TRS working in **any classified position** listed below? Yes ☐ No ☐

- Teacher
- Principal
- Superintendent
- Supervisor/Manager/Director
- Administrator
- Certified Librarian
- Certified/Registered Nurse
- College Professor
- College President, or
- Supervisory/administrative employee whose function is primarily dedicated to public education of any state department, board, board of regents, or board of trustees

If the answer above is YES,  !! You will not be allowed to opt out.

I certify that the information above is true and complete to the best of my knowledge. I understand that by completing this form, I am electing NOT TO PARTICIPATE in TRS and that I can never change this decision. This election follows me to all future eligible nonclassified optional employment at participating TRS employers. I understand this means I will not be allowed to participate in TRS at any TRS employer that I may work for in the future as a nonclassified optional employee. I understand this election is only valid if I am eligible to elect, have no prior classified service, and when completed timely.

Employee's Signature

Date

SECTION TWO – to be completed by employer. Please complete all sections.

Employer

Employer's District Code

Employee's Date of Hire
or Initial Eligibility

Is the employee listed above employed solely in an optional position? Yes ☐ No ☐

If the answer above is NO,  !! The employee will not be allowed to opt out.

I certify that the above-named is an optional employee in the listed position and acknowledge their election.

Signature of Superintendent/Payroll Officer

Date



PAULS VALLEY PUBLIC SCHOOLS

Brett Knight, Superintendent

PO Box 780, Pauls Valley, OK 73075

Phone (405) 238-6453

Fax (405) 238-9178

Rec Center Payroll Deduction Form

Name: _____

Please circle the plan you want:

- Single adult rate: \$30/month \$15/check
- Senior 62+ rate: \$25/month \$12.50/check
- Family rate: \$50/month \$25/check

Are you currently a member of the Rec Center? _____

By signing below, I agree that Pauls Valley Schools may deduct one-half the monthly Rec Center membership from my payroll check, coinciding with my payroll calendar. I understand that this membership will remain in effect until a written request to cancel is received by PVPS Payroll Department.

Signature: _____

Date: _____

PAULS VALLEY PUBLIC SCHOOLS
P.O. Box 780
Pauls Valley, OK 73075
405/238-6453

Verification and Loyalty Oath

I do solemnly swear or affirm that I am not aware of any reason why I cannot properly fulfill the terms of my contract and that I will support, obey and defend the Constitution of the United States and the laws of the State of Oklahoma.

Employee Signature

Date