Daniel J. Strodel
Chief Administrative Officer

Office of the
Chief Administrative Officer
U.S. House of Representatives
Washington, DC 20515-6860

Clear form

Save form

Print ALL pages

Print required and optional pages, NO instructions

U.S. House of Representatives Employee On-Boarding Process

This cover page is intended to facilitate the online completion of these forms using Adobe Reader. The personal information typed on this page will populate into corresponding fields on each applicable page. ***We strongly recommend using Adobe Reader to complete the forms because it will save you time and effort*** and provide the option to print only the pages required to receive a paycheck and benefits or the entire packet with instructions.

Pages two through 18 are required to complete the payroll process. Pages 20-27 are benefit forms that do not need to be completed on the date of hire but will require action by the employee by a certain deadline (see page 19).

Name
First Middle Last

Social Security Number Please enter SSN in format: NNN-NN-NNNN.

Date of Birth Enter DATE in format: MM/DD/YYYY

Address Line 1

Address Line 2

Apartment #

City State Select your state Zipcode

Home Phone Number

Daytime Phone Number

Office Phone Number

Enter PHONE Numbers in format: 0123456789

Employing Office Name

Today's date or Effective date of forms Enter DATE in format: MM/DD/YYYY

A Payroll Authorization Form (PAF), signed by the Member or Chairman, must accompany this packet. The PAF Smartform may be found on:
HouseNet >Forms Library >Payroll >Payroll Authorization Form (Smart Form).

Please remember to sign ALL forms!

Revised 6/8/2012

OMB No. 1615-0047; Expires 06/30/09

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

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees, citizens, and noncitizens hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen Nationals of the United States

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

OMB No. 1615-0047; Expires 06/30/09

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

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name
Address *(Street Name and Number)*		Apt. #	Date of Birth *(month/day/year)*
,			
City	State	Zip Code	Social Security #
	Select your state		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature — Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name
Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

SKIP THIS SECTION

SKIP THIS SECTION

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**3.** School ID card with a photograph		
		4. Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the 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		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		**5.** Native American tribal document
		8. Native American tribal document		**6.** U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
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		**For persons under age 18 who are unable to present a document listed above:**		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		10. School record or report card		**8.** Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

U.S. HOUSE OF REPRESENTATIVES
OATH OF OFFICE
PAYROLL AND BENEFITS INFORMATION

PLEASE USE TYPEWRITER OR PRINT IN INK

A. IDENTIFICATION:

, ,

Name: Last-First-Middle

Date of Birth (Month/Day/Year)

Social Security Number

Office Telephone Number (Include Area Code)

Employing Office

Home Telephone Number (Include Area Code)

B. MAILING ADDRESS FOR EARNINGS STATEMENT AND W-2:

, Select your state,

IN ORDER TO RECEIVE ANY PAY FOR SERVICES, all new and returning employees, and employees taking a break in service must complete Parts C through H.

C. OATH OF OFFICE:

I, , , do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

Signature (Required for Appointment)

Date

D. BENEFITS DEADLINE ACKNOWLEDGEMENT:

I understand that from the date of my appointment, I must enroll in Health Benefits (SF2809) and Thrift Savings Plan (TSP-1) within 60 days. Failure to submit these forms will exclude me from enrollment, in most cases, until Open Season. I have 60 days to elect additional optional life insurance unless a prior election remains in force. Basic premiums for Life Insurance will be withheld from my pay unless I submit a waiver (SF2817) before the 15th of the month. I have 60 days from the date of my appointment to apply for abbreviated underwriting under the Federal Long Term Care (LTC) Insurance Program. I have 60 days from the date of my appointment to apply for the Flexible Spending Accounts (FSAFEDS), or the Dental & Vision Insurance Program (FEDVIP) programs.

Signature (Required for Appointment)

Date

E. WORKERS COMPENSATION INFORMATION:

I ☐ have ☐ have not, received or made application for loss wage compensation under the Federal Employees Compensation Act (job-related injury).

If you have, show: Claim Number _____ Period of Compensation – From: _____ To: _____

SSN:_____

F. PREVIOUS FEDERAL CIVILIAN SERVICE:

1. House of Representatives ☐ Yes ☐ No If Yes, last termination date _____
2. **Other Federal Civilian Service** ☐ Yes ☐ No If Yes, last termination date _____
3. PLEASE LIST BELOW ALL PRIOR FEDERAL CIVILIAN SERVICE: **Include the Senate, Architect of the Capitol, the District of Columbia or a Non-Appropriated Fund Instrumentality (NAFI). (Do not include unpaid internships). (Do not include Active Duty Military Service - See Section 5 below).**

Department or Agency	Date Appointed	Date Separated

Last Personnel Office Phone Number _____

4. While employed as above, my benefits status was:
   - (a) Federal Employees' Health Insurance: ☐ Enrolled _____ Code ☐ Not Enrolled ☐ Excluded
   - (b) Federal Employees' Life Insurance: ☐ Basic ☐ A ☐ B ___ x Times Did You Port Option B? ☐ Y ☐ N
     ☐ C ___ x Times ☐ Waived ☐ Excluded
   - (c) Do you have a FEGLI court order on file? ☐ Yes ☐ No
   - (d) Covered by: ☐ FICA ☐ FICA/FERS ☐ FICA/CSR Offset ☐ CSR only
     Transfer to FERS: ☐ Yes ☐ No
     Thrift Savings Plan employee contribution: $ _____ or _____ %
     TSP 50+ Catchup Contribution $_____
     Do you have a current TSP Loan? ☐ Yes If Yes, loan payment amount _____ ☐ No
   - (e) Refund of CSR contributions: ☐ Yes Date of Refund: _____ ☐ No
   - (f) Federal Long Term Care (LTC) Program

     If you currently have LTC and are paying by payroll deduction, the House does not currently provide payroll deduction option for this benefit and your must arrange for an alternative form of payment.
5. **Active Military Service - Branch:** _____ From: _____ To: _____
   (a) Are you returning from Active Military Service which interrupted your Federal Civilian Service? ☐ Y ☐ N
6. Other Names Used (if different from your present signature): _____
7. I took a Voluntary Separation Incentive. ☐ Yes ☐ No

G. PENSION BENEFITS:

I ☐ am ☐ am not, receiving a pension annuity, or retired pay from the United States Government. (If Yes, please furnish source and claim number below.) **Type of Payment:**

- ☐ Civil Service/FERS: Claim Number _____ Retirement Date _____
- ☐ Alternative Form of Annuity (AA) Lump Sum
- ☐ Military Retiree's Pay-Branch of Service _____ Rank _____ Retirement Date _____
- ☐ Veteran's Benefit: Combat Related ☐ Yes ☐ No
- ☐ Social Security ☐ Foreign Service ☐ CIA ☐ DC Police or Firefighter's Benefit ☐ Other _____

H. CERTIFICATION:

I certify, under penalty of law, that the information provided above is correct and complete.

_____ _____

Signature (Required for appointment) Date

SKIP THIS SECTION

Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child	G
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	H

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Clear Form | Print Form

This is an interactive form, you may fill it out online using the Adobe Reader, then print it.

OMB No. 1545-0074

2012

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route) ,	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code , Select your state,	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	

5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)	5
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2012, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►	7

This form is only used to estimate the Federal taxes that you wish to have deducted from your paycheck. Do NOT submit this form. Please enter the results of your calculations on the form on page 3.

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	**1**	$
2	Enter: { $11,900 if married filing jointly or qualifying widow(er); $8,700 if head of household; $5,950 if single or married filing separately }	**2**	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	**3**	$
4	Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 505)	**4**	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2012 Form W-4* worksheet in Pub. 505.)	**5**	$
6	Enter an estimate of your 2012 nonwage income (such as dividends or interest)	**6**	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	**7**	$
8	**Divide** the amount on line 7 by $3,800 and enter the result here. Drop any fraction	**8**	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	**9**	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	**1**	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	**2**	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	**3**	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	**4**	
5	Enter the number from line 1 of this worksheet	**5**	
6	**Subtract** line 5 from line 4	**6**	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	**7**	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	**8**	$
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	**9**	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 12,000	1	8,001 - 15,000	1
12,001 - 22,000	2	15,001 - 25,000	2
22,001 - 25,000	3	25,001 - 30,000	3
25,001 - 30,000	4	30,001 - 40,000	4
30,001 - 40,000	5	40,001 - 50,000	5
40,001 - 48,000	6	50,001 - 65,000	6
48,001 - 55,000	7	65,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 72,000	9	95,001 - 120,000	9
72,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $70,000	$570	$0 - $35,000	$570
70,001 - 125,000	950	35,001 - 90,000	950
125,001 - 190,000	1,060	90,001 - 170,000	1,060
190,001 - 340,000	1,250	170,001 - 375,000	1,250
340,001 and over	1,330	375,001 and over	1,330

This form is only used to estimate the Federal taxes that you wish to have deducted from your paycheck. Do NOT submit this form. Please enter the results of your calculations on the form on page 3.

Employee's Withholding Allowance Certificate
2012 Substitute Form W-4

Employer identification number: 53-6002523 F

U.S. House of Representatives
Office of Payroll & Benefits
B215 Longworth HOB
Washington, DC 20515

NAME _____
Last First Middle

If your last name differs from that on your social security card, call 1-800-772-1213.

ADDRESS _____

_____

, Select your state,

SOCIAL SECURITY NUMBER _____

FEDERAL TAX WITHHOLDING

Marital Status: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate

Note: *If married, but legally separated, or spouse is a nonresident alien, check the Single block.*

Total number of allowances you are claiming . . . . . .

Additional amount, if any, you want deducted from each paycheck . . . . . $

I claim exemption from withholding for 2012 and I certify that I meet **ALL** of the following conditions for exemption:

- Last year I had a right to a refund of **ALL** Federal income tax withheld because I had **NO** tax liability; **AND**
- This year I expect a refund of **ALL** Federal income tax withheld because I expect to have **NO** tax liability.

If you meet both conditions, enter "EXEMPT" here > > > > > > >

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or entitled to claim exempt status.

SIGNATURE X _____ **Date** _____

STATE TAX WITHHOLDING

I authorize the following action regarding State Income Tax Withholding:

(1) ☐ Begin Withholding (2) ☐ Change Existing Deduction (3) ☐ Stop Withholding

Complete the following information only if Box 1 or 2 is checked above.

STATE: Select your state **County (Maryland residents only):** _____

Marital Status: ☐ Single ☐ Married Select your MD (

If you are a resident of Connecticut, Georgia or Mississippi and claimed Married, select withholding option to the right that you wish to claim. > > > > >

☐ 03 - Married Filing Separate
☐ 04 - Married Both Spouses Working
☐ 05 - Married One Spouse Working
☐ 06 - Head of Household

Total number of allowances you are claiming . . . . . .

Additional amount, if any, you want deducted from each paycheck . . . . . $

SIGNATURE X _____ **Date** _____

Withholding of State taxes is a voluntary program with the House of Representatives.
However, employees should pay estimated State taxes in accordance with State law (see following sheet or reverse).

STATE TAX WITHHOLDING REGULATIONS,

1. All election authorizations, revocations, or changes for withholding State tax from salaries must be made on the prescribed form issued by the House of Representatives, Office of Payroll & Benefits.

2. An employee may have only one request for State withholding in effect at any one time.

3. An employee may not have more than two such requests with respect to different states during any one calendar year.

4. Election for withholding is **optional** and an employee may revoke such election.

5. Election, change, or revocation of State tax withholding is effective on the first day of the month in which the request is processed by the Office of Payroll & Benefits, but in no event later than the first day of the first month beginning after the day on which such election, change, or revocation is received by the Office of Payroll & Benefits, with the following exception: when an employee first receives an appointment, his/her request shall be effective on the day of the appointment if the request is made at that time.

STATE ABREVIATIONS
(For use in completing State Tax Withholding)
TWO-LETTER STATE ABBREVIATIONS

Alabama	AL	Louisiana	KY	Oklahoma	OK
Alaska	AK	Maine	ME	Oregon	OR
Arizona	AZ	Maryland	MD	Pennsylvania	PA
Arkansas	AR	Massachusetts	MA	Puerto Rico	PR
California	CA	Michigan	MI	Rhode Island	RI
Colorado	CO	Minnesota	MN	South Carolina	SC
Connecticut	CT	Mississippi	MS	South Dakota	SD
Delaware	DE	Missouri	MO	Tennessee	TN
District of Columbia	DC	Montana	MT	Texas	TX
Florida	FL	Nebraska	NE	Utah	UT
Georgia	GA	Nevada	NV	Vermont	VT
Hawaii	HI	New Hampshire	NH	Virginia	VA
Idaho	ID	New Jersey	NJ	Washington	WA
Illinois	IL	New Mexico	NM	West Virginia	WV
Indiana	IN	New York	NY	Wisconsin	WI
Iowa	IA	North Carolina	NC	Wyoming	WY
Kansas	KS	North Dakota	ND		
Kentucky	KY	Ohio	OH		

FEDERAL WITHHOLDING

Copies of the Internal Revenue Service *Employee's Personal Allowance Worksheet* for Form W-4 can be obtained from the Office of Payroll & Benefits B215 Longworth HOB, Washington, DC 20515.

Direct Deposit Form

Instructions:

1. This form can be used to identify up to two (2) direct deposit accounts.
2. Complete all sections of this form, print, and return with all required supporting documents to the Office of Payroll and Benefits.
3. This form(s) ***will not*** be processed if submitted with incomplete information.
4. This form(s) ***will not*** be processed if submitted without an accompanying voided check ***or*** an ACH routing document ***provided by your financial institution***.
5. This office reserves the right to pull back any funds sent to your financial institution in error.
6. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Direct Deposit Form

Date: _____

First Name: _____

Last Name: _____

Employee Number (***found on your earning statement***): _____

Address: _____

City, State Zip: _____, Sele, _____

Email: _____

Return the completed form(s) and accompanying documents to:

Office of Payroll and Benefits
B-215 Longworth House Office Building
Washington, D.C. 20515
(202) 225-1435 phone
(202) 225-5969 fax

Daytime Telephone: _____ **Evening Telephone:** _____

On this page you may only select a Primary or a Secondary account.

New ☐ Change ☐

Primary Direct Deposit Account
The account you want the balance of your salary to go to.
If you don't have a Secondary Direct Deposit Account, all funds will go to this account.

New ☐ Change ☐ Cancel ☐

Secondary Direct Deposit Account (choose % or $ and enter value below)
A portion of your salary goes to this account.
You must designate either a % (less than 100%) or a dollar value you want sent to this account.

(If secondary Direct Deposit) Enter value for ☐ **%** (less than 100%) ☐

Is this a Checking ☐ or Savings ☐ account?

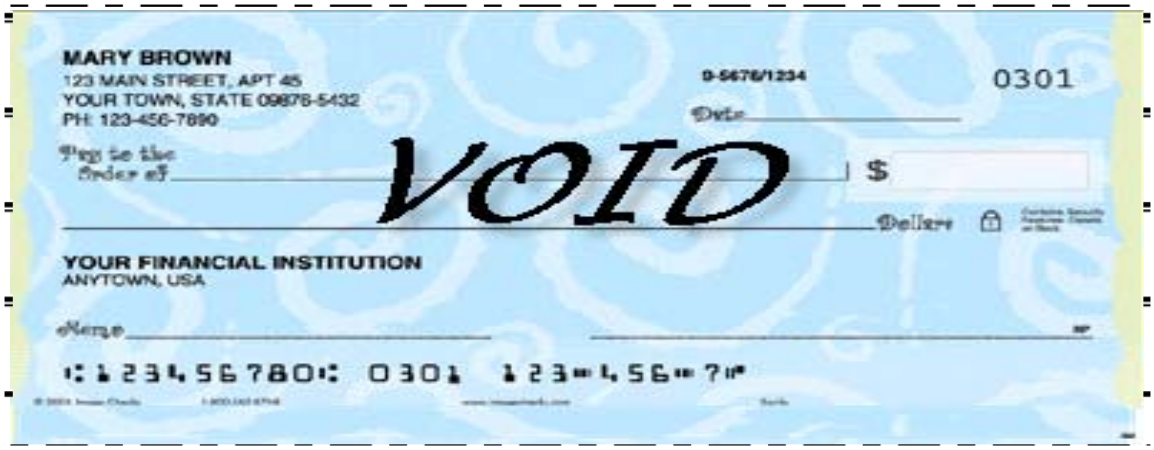
Financial Institution Name: _____

Financial Institution Address: _____

Financial Institution City, State Zip: _____

Financial Institution Phone Number: _____

Affix voided check here (use tape please) – or append ACH routing form from your banking institution



PLEASE READ THE FOLLOWING INFORMATION BEFORE SUBMITTING:

1. These forms ***will not*** be processed without an accompanying voided check ***or*** an ACH routing document ***provided by your financial institution***.
2. This office reserves the right to pull back any funds sent to your financial institution in error.
3. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Signature: _____

Direct Deposit Form

Date: _____

First Name: _____

Last Name: _____

Employee Number (***found on your earning statement***): _____

If you would you like to add another (secondary) Direct Deposit Account please fill in the information below, otherwise, print and sign the forms then submit the forms as noted.

Return the completed form(s) and accompanying documents to:

Office of Payroll and Benefits
B-215 Longworth House Office Building
Washington, D.C. 20515
(202) 225-1435 phone
(202) 225-5969 fax

New ☐ Change ☐ Cancel ☐

Secondary Direct Deposit Account (choose either a % or $ and enter value below)

A portion of your salary goes to this account.
You must designate either a % (less than 100%) or a dollar value you want sent to this account

Enter value for ☐ **%** (less than 100%) OR **$** ☐

Is this a Checking ☐ or Savings ☐ account?

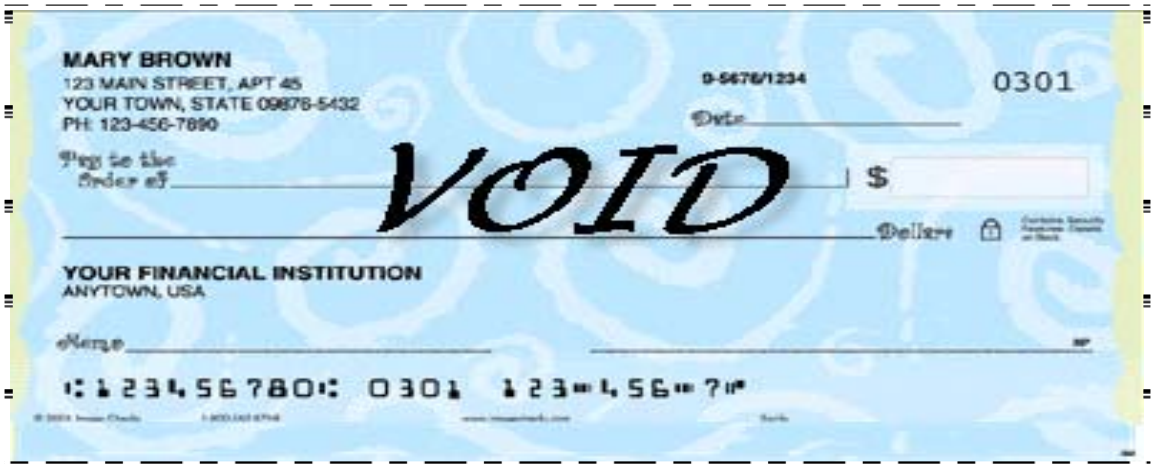
Financial Institution Name: _____

Financial Institution Address: _____

Financial Institution City, State Zip: _____

Financial Institution Phone Number: _____

Affix voided check here (use tape please) – or append ACH routing form from your banking institution



PLEASE READ THE FOLLOWING INFORMATION BEFORE SUBMITTING:

4. These forms ***will not*** be processed without an accompanying voided check ***or*** an ACH routing document ***provided by your financial institution***.
5. This office reserves the right to pull back any funds sent to your financial institution in error.
6. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Signature: _____

Active Employees can make TSP enrollment changes via EmployeeExpress.gov, click here

THRIFT SAVINGS PLAN
ELECTION FORM

TSP-1

Use this form to start, stop, or change the amount of your contributions to the Thrift Savings Plan (TSP).

Before completing this form, please read the *Summary of the Thrift Savings Plan* and the instructions on the back of this form. Type or print all information. **Return the completed form to your agency personnel or benefits office.** Your agency should return a copy to you after completing Section V.

Note: To choose your investment funds, see the instructions in the General Information section on the back of this form.

I. INFORMATION ABOUT YOU

1. _____
Name *(Last)* *(First)* *(Middle)*

2. , , Select your state,
Street Address City State Zip Code

3. _____ _____ _____
Social Security Number

4. _____ _____ _____
Daytime Phone *(Area Code and Number)*

5. U.S. HOUSE OF REPRESENTATIVES
Office Identification *(Agency and Organization)*

II. CHOOSE THE AMOUNT OF YOUR CONTRIBUTIONS

Your choice will cancel all previous elections.

To start or change the amount of traditional (pre-tax) or Roth (after-tax) contributions to your TSP account, enter **either** a whole percentage of your basic pay per pay period **or** a whole dollar amount per pay period for each type of contribution you elect. (You may choose a percentage for one type of contribution and a dollar amount for the other type of contribution.) **Remember:** A blank line next to a type of contribution equals 0% or $0 contributed.

6. Traditional (Pre-Tax) Contributions _____ .0% **OR** **7.** $ _____ .00

8. Roth (After-Tax) Contributions _____ .0% **OR** **9.** $ _____ .00

Contact the Office of Payroll & Benefits at (202) 225-1435 before electing a dollar amount.

III. STOP SOME OR ALL OF YOUR CONTRIBUTIONS

To stop all or any portion of your contributions to the TSP, check the box in Item 10 that applies and complete Section IV. Your payroll contributions will stop no later than the first full pay period after your agency employing office receives this form. (If you are a Federal Employees' Retirement System (FERS) employee, and you stop your contributions, your Agency Matching Contributions will stop, but Agency Automatic (1%) Contributions will continue. Read the instructions on the back.)

10. ☐ I choose not to save for my retirement. Please stop all my payroll contributions to my TSP account.

☐ Stop only my traditional (pre-tax) payroll contributions to my TSP account.

☐ Stop only my Roth (after-tax) payroll contributions to my TSP account.

If you are a newly hired (or rehired) employee, you can generally stop your automatic employee contributions before they start if you submit this form to your agency before the end of your first full pay period. (See note on back.)

IV. SIGNATURE

11. _____
Participant's Signature

12. ____/____/____
Date Signed *(mm/dd/yyyy)*

V. FOR EMPLOYING OFFICE USE ONLY

13. 00004832
Payroll Office Number

14. ____/____/____
Receipt Date *(mm/dd/yyyy)*

15. ____/____/____
Effective Date *(mm/dd/yyyy)*

16. _____
Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request the information you provide on this form under 5 U.S.C. chapter 84, Federal Employees' Retirement System. Your agency or service will use this information to identify your TSP account and to start, change, or stop your TSP contributions. In addition, this information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. The information may also be shared with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. Relevant portions of the information may also be disclosed to appropriate parties engaged in litigation and for other routine uses as specified in the Federal Register. You are not required by law to provide this information, but if you do not provide it, your agency or service will not be able to process your request.

Contact the Office of Payroll & Benefits at (202) 225-1435 before electing a dollar amount.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

Form TSP-1 (5/2012)
PREVIOUS EDITIONS OBSOLETE

INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

You may start, stop, or change your contributions at any time. Your TSP election will stay in effect until you submit another election or until you leave Federal service. (This form only applies to regular contributions. If you are age 50 or older and want to make or change catch-up contributions, use Form TSP-1-C, Catch-Up Contribution Election.)

Important note for new TSP participants: All contributions to your account will be invested in the Government Securities Investment (G) Fund until you direct the TSP to allocate your contributions differently. The TSP publication *Summary of the Thrift Savings Plan* describes all of your investment choices and discusses their risks and advantages. For more information, you can also obtain a copy of the TSP Fund Information sheets. (The most current versions of TSP forms and publications are available on the TSP website at www.tsp.gov.)

To choose your investment fund(s), use the TSP website (www.tsp.gov) or the ThriftLine at 1-TSP-YOU-FRST (1-877-968-3778; outside the U.S. and Canada, call 404-233-4400). On the TSP website, you will need your TSP account number (or user ID) and 8-character Web password. If you use the ThriftLine, you will need your TSP account number and 4-digit ThriftLine Personal Identification Number (PIN). If you are a new participant, your TSP account number, ThriftLine PIN, and Web password will be mailed to you (separately) after your account has been established.

If you change your address, notify your **agency** immediately to correct your records for your TSP account.

SECTION I

Complete all items in this section.

SECTION II

Your choice will cancel all previous elections.

Example

Previous Election:

Traditional **5%**
Roth **2%**

New Election:

Traditional **5%**
Roth **10%**

Complete this section to start your TSP contributions or to change the amount and type of contributions. Because whatever you enter in this section will cancel all previous elections, be sure to indicate exactly what percentages/amounts you want to contribute, even if part of your election has not changed (see the example in the margin). You can elect to make traditional (pre-tax) and Roth (after-tax) contributions simultaneously. **Traditional contributions** come out of your pay **before** income taxes are calculated; you pay income taxes on these contributions and their earnings when you withdraw them. **Roth contributions** are made from your pay **after** taxes, and the earnings grow in your account tax-deferred. Withdrawals of Roth contributions are tax-free. The earnings associated with Roth contributions are also tax-free, but only if 5 years have passed since January 1 of the calendar year in which you made your first Roth contribution, **and** you have reached age 59½, have a permanent disability, or have died. **Note for FERS:** All agency contributions to your account are tax-deferred, even if they are matching your Roth contributions.

Complete **either** Item 6 **or** Item 7 (not both) for traditional (pre-tax) contributions; **either** Item 8 **or** Item 9 (not both) for Roth contributions. You may choose a percentage of basic pay for one type of contribution and a dollar amount (as little as $1) for the other type of contribution.

If you choose a percentage of basic pay, your contribution amount will automatically increase when you receive a pay raise.

If you choose a dollar amount per pay period, your contribution amount will not increase when you receive a pay raise; you must submit a new Form TSP-1 to change the amount.

Contribution limit. The **total** of your traditional and Roth contributions cannot exceed the Internal Revenue Code (IRC) annual elective deferral limit ($17,000 in 2012). Since the elective deferral limit may be adjusted annually for inflation, check the TSP website, www.tsp.gov, to be sure that you have the most up-to-date limit amount (and the most recent version of this form).

SECTION III

Complete Item 10 to stop all (or just one type) of your contributions. You may restart your contributions at any time.

FERS employees: Your Agency Automatic (1%) Contributions will continue after you stop your employee contributions, but you will no longer receive valuable Agency Matching Contributions. (If you restart your contributions, the matching contributions will resume.)

Note for newly hired or rehired FERS or CSRS employees: As a new employee, your agency automatically deducts 3% of your pay, tax-deferred, and deposits the money in your TSP account for your retirement savings. If you want all or any portion of your automatic contributions to be after-tax Roth contributions, **you must complete Section II** and indicate what percentages or amounts you want as traditional (pre-tax) and Roth (after-tax) contributions. You can stop your automatic employee contributions before they start if you submit this form to your agency at the start of your first full pay period, subject to your agency's processing deadlines. If your agency has already begun to deduct your automatic employee contributions from your pay each pay period, you are entitled to request a refund of your initial contributions by submitting Form TSP-25, Automatic Enrollment Refund Request. The TSP must receive Form TSP-25 within 90 days of your first contribution.

SECTION IV

You must complete this section.

SECTION V

(To be completed by personnel or benefits office)

The Receipt Date (Item 14) is the date that a **properly completed** form is received by the agency personnel office. If the form has not been properly completed, it should be returned to the employee.

Requests must be processed immediately for new and rehired employees who want to stop automatic enrollment before it begins. This will help avoid a payroll deduction that may have to be refunded. The Effective Date (Item 15) must be no later than the first full pay period after receipt of a properly completed form.

You should provide the participant with a copy of this completed election form.

U.S. House of Representatives
Washington, D.C. 20515

Certificate of Relationship/Nonrelationship to Any Current Member of Congress

Date _____

To: _____
(Employing Authority)

☐ I certify that I do not have any of the following relationships to any current Member of Congress.

father	nephew	sister-in-law
mother	niece	stepfather
son	husband	stepmother
daughter	wife	stepson
brother	father-in-law	stepdaughter
sister	mother-in-law	stepbrother
uncle	son-in-law	stepsister
aunt	daughter-in-law	half-brother
first cousin	brother-in-law	half-sister

☐ I certify that I am the _____ of the
(Relationship)

Honorable _____.
(Name of Member to whom related)

_____
(Employee)

U.S. GOVERNMENT PRINTING OFFICE: 1995 87-660 (Mac)

U.S. House of Representatives
Principles of Behavior for Information System Users

GUIDELINES FOR USE OF INFORMATION SYSTEMS

The following principles apply to House employees and contractors using or providing support for House information systems. Additional guidance unique to specialized systems may be provided as needed. These principles are based on Federal law, the House Code of Official Conduct, Committee on House Administration (CHA) Regulations, and House Information Security Policies (HISPOLs). At the discretion of the Employing Authority, there may be consequences for non-compliance.

USERS ARE RESPONSIBLE FOR ALL ACTIONS PERFORMED WITH THEIR PERSONAL USER ID.

- Users shall make every effort to protect information security through effective use of user IDs and passwords.
- User IDs and passwords are for individual use only.
- Users must not disclose their passwords to anyone. Users must take necessary steps to prevent anyone from gaining knowledge of their passwords.

REGULATIONS, POLICIES, AND PROCEDURES MUST BE FOLLOWED.

- House information systems may not be used contrary to public law, House Rules, CHA regulations, and HISPOLs.
- All computer resources assigned, controlled, assessed, and maintained by House employees and contractors are subject to periodic test, review, and audit.

ACCESS TO INFORMATION MUST BE CONTROLLED.

- Users must access and use only information for which they have official authorization.
- Users must protect information from unauthorized disclosure or modification.
- Users must protect information so that it is available on a timely basis to meet House operational requirements.

USERS ARE RESPONSIBLE FOR THE PROPER USE OF COMPUTER RESOURCES.

- Users are accountable for their own actions and responsibilities related to information and information systems entrusted to them.
- Users must protect computer equipment from damage, abuse, theft, sabotage, and unauthorized use.
- Users must use approved software in a safe manner so that it is protected from damage, abuse, theft, sabotage, and unauthorized replication or use (copyright infringement).
- Users must participate in annual security awareness training to ensure their knowledge of current policies and procedures.
- Users must report suspected security violations, incidents, and vulnerabilities to the Information Systems Security Office.

USER CERTIFICATION

I certify that I have read the above statements, fully understand my responsibilities, and agree to comply. I recognize that any violation of the requirements indicated above may be cause for disciplinary actions.

Name (please print): _' '_____

Signature: _____

Date: _____

The following pages are optional forms that do NOT have to be completed on the date of hire. If you wish to apply for these benefits you MUST apply by the deadlines noted below.

Program	Form	Time Limit for application
TSP	TSP-1C	For Staffers age 50 and over, may enroll at any time.
Health	SF-2809	Within 60 days of your appointment **or** enroll on-line at www.employeeexpress.com within 60 days of your appointment.
Life	SF-2817	Within 60 days of your appointment.

Supplemental Dental and Vision enrollment is conducted on-line at www.benefeds.com Within 60 days of your appointment.

Flexible Spending Account enrollment is conducted on-line at www.FSAFEDS.com Within 60 days of your appointment.

THRIFT SAVINGS PLAN
CATCH-UP CONTRIBUTION ELECTION

TSP-1-C

Use this form to start, stop, or change your "catch-up" contribution election to your TSP account. You are eligible to make catch-up contributions **if you are age 50 or older** (or if you will become age 50 during the calendar year for which you are making this election), **and** you are already contributing a percentage or a dollar amount which will result in reaching the Internal Revenue Code (IRC) elective deferral limit by the end of the year. (See back of form.) Catch-up contributions will be taken from your basic pay each pay period and invested according to your most recent contribution allocation; they are in addition to your regular TSP contributions.

Before completing this form, read the information on the back. Type or print all information. **Return the completed form to your agency.**

I. INFORMATION ABOUT YOU

1. _____
Name *(Last)* *(First)* *(Middle)*

2. , , Select your state,
Street Address City State Zip Code

No

3. _____ _____ _____
Social Security Number

4. _____ _____ _____
Daytime Phone *(Area Code and Number)*

5. U.S. House of Representatives
Office Identification *(Agency and Organization)*

II. CHOOSE THE AMOUNT OF YOUR CATCH-UP CONTRIBUTIONS

You must be in pay status. (See back of form.)

Your choice will cancel all previous elections.

To start or change your catch-up contributions, complete Items 6, 7, and 8. Use whole dollar amounts. (See additional instructions on the back of the form.) **Remember:** A blank line next to a type of contribution is equal to $0 contributed.

6. I elect to contribute the following catch-up contributions per pay period:

$_____.00 Traditional (Pre-Tax)
$_____.00 Roth (After-Tax)

} Total cannot exceed $5,500 for the calendar year.

I understand that my election will continue until:

- the end of the calendar year; or
- I reach the annual limit for catch-up contributions; or
- I submit a new election to stop or change these contributions.

I certify that I will make regular contributions to the TSP or an equivalent employer plan up to the maximum amount allowed by the IRS and TSP plan rules. I understand that my catch-up contributions are in addition to my regular TSP contributions.

7. _____
Participant's Signature

8. _____
Date Signed *(mm/dd/yyyy)*

III. STOP SOME OR ALL OF YOUR CATCH-UP CONTRIBUTIONS

I understand that I must make a new election to resume these contributions.

9. I want to stop the catch-up contributions indicated below:

- ☐ All catch-up contributions
- ☐ Traditional (pre-tax) catch-up contributions only
- ☐ Roth (after-tax) catch-up contributions only

10. _____
Participant's Signature

11. / /
Date Signed *(mm/dd/yyyy)*

IV. FOR EMPLOYING OFFICE USE ONLY

12. 00004832
Payroll Office Number

13. / /
Receipt Date *(mm/dd/yyyy)*

14. / /
Effective Date *(mm/dd/yyyy)*

15. _____
Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request the information you provide on this form under 5 U.S.C. chapter 84, Federal Employees' Retirement System. Your agency will use this information to identify your TSP account and to start, change, or stop your TSP contributions. In addition, this information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. The information may also be shared with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. Relevant portions of the information may also be disclosed to appropriate parties engaged in litigation and for other routine uses as specified in the Federal Register. You are not required by law to provide this information, but if you do not provide it, your agency or service will not be able to process your request.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

Form TSP-1-C (5/2012)
PREVIOUS EDITIONS OBSOLETE

INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

Catch-up contributions are in addition to your regular TSP contributions. Therefore, if you are not already contributing the maximum amount allowed by the Internal Revenue Code ($17,000 in 2012) through your regular TSP contributions or by contributing to an equivalent employer plan (e.g., a 401(k) plan), you must elect to contribute the maximum amount before you are eligible to make catch-up contributions. This catch-up election **will not** affect your regular TSP contributions.

You may start, stop, or change your catch-up contributions at any time. Your election will stay in effect subject to the conditions in Section II below. You must make a new election for each calendar year.

You do not receive matching contributions from your agency for any catch-up contributions.

Your catch-up contribution election will be effective no later than the first full pay period after your agency receives it. Contributions will be invested according to your most recent contribution allocation on file. If you wish to change your contribution allocation, you may do so on the TSP website at www.tsp.gov, or the ThriftLine at 1-TSP-YOU-FRST (1-877-968-3778; outside the U.S. and Canada, call 404-233-4400).

SECTION I

Complete all items in this section.

SECTION II

Your choice will cancel all previous elections.

Your contribution election. You can elect to make traditional (pre-tax) and Roth (after-tax) catch-up contributions simultaneously. Whatever you enter in this section will cancel all previous elections; therefore, be sure to indicate exactly what amounts you want to contribute, even if part of your election has not changed. **Traditional contributions** come out of your pay **before** income taxes are calculated; you pay income taxes on these contributions and their earnings when you withdraw them. **Roth contributions** are made from your pay **after** taxes. Withdrawals of Roth contributions are tax-free. The earnings associated with these contributions are also tax-free, but only if 5 years have passed since January 1 of the calendar year in which you made your first Roth contribution, **and** you have reached age 59½, have a permanent disability, or have died.

Contribution limits. The IRC limit for catch-up contributions is $5,500 in 2012. The **total** of your traditional and Roth catch-up contributions cannot exceed this limit. IRC limits may be adjusted annually for inflation. Check the TSP website, www.tsp.gov, to be sure that you have the most up-to-date limit amount (and the most recent version of this form).

Deductions will be made from your basic pay in the dollar amount you indicate. However:

(1) Catch-up contributions will stop when you have reached the maximum allowable dollar amount for the calendar year.

(2) The catch-up contribution amount you specified cannot exceed the amount of your pay after all other required deductions have been made. (Required deductions include regular TSP contributions and TSP loan payments.)

(3) Your catch-up contributions will **not** continue into the next calendar year.

You are not eligible to make catch-up contributions if you are in nonpay status or if you are ineligible to make TSP contributions because you have made a financial hardship in-service withdrawal within the last 6 months. If you have elected to make catch-up contributions and you subsequently enter a noncontribution period, deductions will stop. Contributions will **not** restart automatically. You must submit a new election when your noncontribution period ends.

You may stop your catch-up contributions at any time by submitting a new Form TSP-1-C to your agency indicating that you want your election to stop. (See Section III.)

You must sign this section. If you do not, your request to start or change your catch-up contributions will be rejected.

SECTION III

If you choose to stop all, or just one type, of your catch-up contributions, you must complete and sign this section. Your election should be effective the first pay period after your agency receives it. You can restart your catch-up contributions at any time, subject to the conditions above. Do **not** complete this section if you have completed Section II. Your election in Section II cancels your previous election.

SECTION IV

(To be completed by personnel or benefits office)

The Receipt Date (Item 13) is the date that a **properly completed** form is received by the agency personnel office. If the form has not been properly completed, it should be returned to the employee.

The Effective Date (Item 14) must be no later than the first full pay period after receipt of a properly completed form.

You should provide the participant with a copy of this completed election form.

Federal Employees
Health Benefits Program

Form Approved:
OMB No. 3206-0160

Health Benefits Election Form

Part A - Enrollee and Family Member Information ***(For additional family members use a separate sheet and attach.)***

1. Enrollee name *(last, first, middle initial)*
, ,

2. Social Security number

3. Date of birth *(mm/dd/yyyy)*

4. Sex
☐ M ☐ F

5. Are you married?
☐ Yes ☐ No

6. Home mailing address *(including ZIP Code)*
,

, Select your state,

7. If you are covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

8. Medicare Claim Number

9. Are you covered by insurance other than Medicare?
☐ Yes, indicate in item 10 below. ☐ No

10. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

11. Name of family member *(last, first, middle initial)*

12. Social Security number

13. Date of birth *(mm/dd/yyyy)*

14. Sex
☐ M ☐ F

15. Relationship code

16. Address *(if different from enrollee)*

17. If you are covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

18. Medicare Claim Number

19. Are you covered by insurance other than Medicare?
☐ Yes, indicate in item 20 below. ☐ No

20. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

21. Email address *(if home address is different from enrollee's)*

22. Preferred telephone number *(if home address is different from enrollee's)*

23. Name of family member *(last, first, middle initial)*

24. Social Security number

25. Date of birth *(mm/dd/yyyy)*

26. Sex
☐ M ☐ F

27. Relationship code

28. Address *(if different from enrollee)*

29. If you are covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

30. Medicare Claim Number

31. Are you covered by insurance other than Medicare?
☐ Yes, indicate in item 32 below. ☐ No

32. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

33. Email address *(if home address is different from enrollee's)*

34. Preferred telephone number *(if home address is different from enrollee's)*

35. Name of family member *(last, first, middle initial)*

36. Social Security number

37. Date of birth *(mm/dd/yyyy)*

38. Sex
☐ M ☐ F

39. Relationship code

40. Address *(if different from enrollee)*

41. If you are covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

42. Medicare Claim Number

43. Are you covered by insurance other than Medicare?
☐ Yes, indicate in item 44 below. ☐ No

44. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other: *Name of other insurance:* _____ *Policy number:* _____

☐ FEHB *An FEHB self and family enrollment covers all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

45. Email address *(if home address is different from enrollee's)*

46. Preferred telephone number *(if home address is different from enrollee's)*

(continued on the reverse)

Part B - FEHB Plan You Are Currently Enrolled In ***(if applicable)***

1. Plan name
2. Enrollment code

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name
2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel ***(see page 2)***

1. Event code
2. Date of event _ _ / _ _ / _ _ _ _

Part E - Election NOT to Enroll ***(Employees Only)***

☐ I do NOT want to enroll in the FEHB Program.

My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

☐ I CANCEL my enrollment.

My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB ***(Annuitants/Former Spouses Only)***

☐ I SUSPEND my enrollment.

My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*
2. Date *(mm/dd/yyyy)* _ _ _ _ _ _ _ _
3. Email address
4. Preferred telephone number ( )

Part I -To be completed by agency or retirement system

REMARKS

1. Date received *(mm/dd/yyyy)*
2. Effective date of action *(mm/dd/yyyy)*
3. Personnel telephone number (202) 225-1435
4. Name and address of agency or retirement system

Office of Payroll & Benefits
U.S. House of Representatives
B215 Longworth HOB
Washington, DC 20515

5. Authorizing official *(please print)*
6. Signature of authorized agency official
7. Payroll office number 00004832
8. Payroll office contact *(please print)* Employee Services Generalist
9. Payroll telephone number (202) 225-1435

, ,

FEGLI
Federal Employees' Group Life Insurance

Life Insurance Election

Federal Employees' Group Life Insurance Program

See Privacy Act Statement on back of Part 3

Form Approved:
OMB No. 3206-0230

1 **General Instructions**

By law, unless you waive all coverage or are ineligible, you are automatically covered for Basic life insurance as an employee. When you first become eligible for FEGLI, you may (1) do nothing and have Basic automatically, (2) elect Basic and any or all of the options, or (3) waive all life insurance coverage. If you are changing a previous election, see the back of Part 3 - Employee Copy.

- Read the back of Part 3 - Employee Copy carefully.
- Assignees completing this form should read Items 5 and 6 on the back of Part 3.
- Give all parts of your completed form to your employing office. Your employing office will complete Section 6 of this form (or its electronic equivalent) and return your copy to you.

This election supersedes all previous elections.

2 Fill in identifying information concerning the employee.

Name *(last, first, middle)*	Date of birth *(mm/dd/yyyy)*	Social Security Number
, ,		

Employing department or agency	OWCP claim number, if applicable	Location of department or agency where you work *(city, state, ZIP code)*	Daytime telephone number *(including area code)*
U.S House of Representatives		B215 LHOB, Washington, DC, 20515	

3 **To elect or retain Basic,** sign and date below. If you do not sign for Basic, you (or your assignee) may not elect or retain any form of optional insurance. If you do not want any insurance at all, skip to Section 5.

Basic

I want Basic. I authorize deductions to pay my share of the cost. (Basic may be provided without cost to U.S. Postal Service employees.)

SIGNATURE *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* ➡

Date *(mm/dd/yyyy)*

4 **Optional**

If you signed for Basic in item 3 above, you may elect or retain any or all of the following options (UNLESS you have previously waived any or all of these options, in which case you may elect only those options which you are eligible to elect as outlined in the FEGLI Program Booklet). Sign the box(es) below for any option(s) you are eligible for and wish to elect or retain. If you do not sign for an option, you have waived it and your future opportunities to enroll in it are strictly limited.

You will not be covered for any option(s) for which you do not sign below, regardless of whether you previously elected the option(s).

Option A - Standard	Option B - Additional	Option C - Family
I want Option A. I authorize deductions to pay the full cost. ☐	I want Option B in the multiple of my annual basic pay I indicate below. I authorize deductions to pay the full cost. ☐ 1 times my pay ☐ 2 times my pay ☐ 3 times my pay ☐ 4 times my pay ☐ 5 times my pay	I want Option C in the multiple I indicate below. I understand that each multiple is worth $5,000 upon the death of my spouse, and $2,500 upon the death of an eligible child. I authorize deductions to pay the full cost. ☐ 1 multiple ☐ 2 multiples ☐ 3 multiples ☐ 4 multiples ☐ 5 multiples
SIGNATURE *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* ➡	**SIGNATURE** *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* ➡	**SIGNATURE** *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* ➡
Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*

Clear Life Options

5 **If you want NO life insurance coverage,** sign and date below.

Waiver of all life insurance coverage

I want NO life insurance coverage. I understand that any life insurance I have will stop at the end of the last day of the pay period in which my employing office receives this waiver. Further, I cannot get Basic life insurance unless (1) I wait at least 1 year after I sign this form and submit satisfactory medical information, or (2) I experience a life event, or (3) I have a break in Federal service of at least 180 days, or (4) I participate in an open season, which is held infrequently. I understand that I cannot get any optional insurance unless I first have Basic. I understand that my decision to waive life insurance coverage now may affect my eligibility for coverage as a retiree.

SIGNATURE *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* ➡

Date *(mm/dd/yyyy)*

6 **Agency Use** ***Remarks:***

If new/newly eligible employee, enter "0" for event.

Number of event permitting change *(See back of Part 2)*

Name and address of employing office	Date received in employing office *(mm/dd/yyyy)*	Effective date of coverage *(mm/dd/yyyy)*

I followed the instructions on the back of Part 1.

Signature of authorized agency official

The employee's copy of this form, when completed by the employing office, together with the FEGLI Program Booklet (FE 76-21 or FE 76-20 for U.S. Postal Service employees) constitute the employee's Certificate (proof) of Insurance.

PART 3 - Employee Copy

Instructions for Agencies

1. Who Should File This Form?

- New employees eligible for life insurance who want optional insurance or no insurance. **Note:** New employees who want only Basic do not have to file.
- Employees appointed to positions that allow life insurance coverage following service in positions that did not allow life insurance coverage.
- Employees who want to change their life insurance.
- Reinstated employees who filed a previous waiver of any type of life insurance, were separated from service for at least 180 days, and wish to elect coverage.
- Assignees who want to decrease or cancel coverage.
- Department of Defense employees designated "emergency essential" and civilian employees deployed in support of a contingency operation per Public Law 110-417.

Give a new employee a copy of the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) when he or she reports for duty and ask the employee to return the completed SF 2817 as soon as possible (preferably before the end of the first pay period), but no later than 60 days after his or her appointment.

Employees with prior government service in non-excluded positions who were separated after March 31, 1981, should have an SF 2817 on file in their personnel folders, and that election or waiver of coverage may still be in effect. **Do not accept a new SF 2817 unless the employee has a break in Federal service of at least 180 days or is eligible to cancel a previous waiver that has been in effect for at least one year, or wishes to reduce coverage.**

Until you verify an employee's SF 2817 on file, make deductions based on his or her statement about earlier insurance coverage. Once coverage is confirmed, make any necessary adjustments to correct the withholdings.

An employee may at any time file an SF 2817 to waive or reduce coverage, **unless** the employee has assigned his/her insurance coverage. If the employee has assigned the insurance, **only** the assignee(s) may waive or reduce the coverage (except for Option C which cannot be assigned).

2. How Else Can An Employee Elect More Coverage?

- **Provide Medical Information.** An employee may elect or increase Basic, Option A, or Option B insurance (but **not** Option C), if a previously completed SF 2817 waiving coverage has been in effect for more than one year, by submitting satisfactory evidence of insurability via a *Request for Insurance*, SF 2822. If approved, the employee should make the election on the SF 2817 and submit to the employing agency. More details are contained on the SF 2822.
- **Experience A Qualifying Life Event.** An employee may elect Basic, Option A, Option B and/or Option C within 60 days following a FEGLI qualifying life event. These events are: marriage, divorce, spouse's death, or the acquisition of an eligible child.

  For Option B and Option C, an employee may elect from 1 to 5 multiples (up to 5 total) based on the life event.
- An employee who is already enrolled in Option B and/or Option C may elect from 1 to 5 multiples (up to 5 total) within 60 days based on the life event.

3. What Should You Review After The Employee Submits This Form?

Review all three parts of the SF 2817 to see that they are legible and complete. If an employee signs the box for Option A, Option B, or Option C, he or she must also sign Section 3, Basic. If the employee uses a downloaded copy, be sure all parts are completed. Contact the employee if any part is unclear.

Only the employee may sign this form in Sections 3, 4, or 5, with one exception (noted below). Signatures by guardians, conservators, or through a power of attorney are ***NOT*** valid.

Exception: If the employee assigned the insurance, only the assignee(s) may ***waive*** or reduce some or all of the employee's coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to the employee). Please note that assignees cannot increase the employee's coverage. Only the employee can do that.

The employee is solely responsible for ensuring that the SF 2817 accurately reflects his or her intentions.

If the employee is electing new coverage, always make sure that the authorized agency official confirms that the employee is eligible for the coverage, and that the official signs the form in Section 6.

4. When Did You Receive This?

Enter the date the employing office received this form.

5. What Is The Event Permitting The Change?

Enter the number of the event permitting a change, if applicable. See the Table of Effective Dates on the back of Part 2 for event numbers.

6. What Is The Effective Date Of The Coverage?

Enter the effective date of coverage. For new and newly eligible employees: Basic is effective on the first day the employee is in a pay and duty status; Optional coverage is effective on the first day the employee is in a pay and duty status on or after the day the employing office receives the SF 2817. For changes in elections, see the Table of Effective Dates on the back of Part 2. If there is more than one effective date for this election, the 2nd effective date should be notated in Part 6 under "Remarks."

7. What Do You Do With Parts 1, 2, and 3?

After completion, give Part 3 to the employee. File Part 1 in the employee's personnel folder. Destroy Part 2 after payroll office use. Part 3, and the *FEGLI Program Booklet* (FE 76-21, or FE 76-20 for U.S. Postal Service employees), serve as the employee's certificate of insurance.

8. Where Can You Find More Information?

Consult the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) or the FEGLI Handbook, which are available on the FEGLI web site at www.opm.gov/insure/life.

For Information Only

Table of Effective Dates: Changes in Life Insurance Coverage

Deductions: Begin, increase, stop or decrease in the same pay period in which coverage begins, increases, stops, or decreases.

Event Allowing Change	Change Permitted? *(To elect any option, employee must elect or retain Basic)*			
	Basic	**Option A - Standard**	**Option B - Additional**	**Option C - Family**
0. New/Newly Eligible Employee:	**Yes.** See "Instructions to Agencies", #5, back of Part 1.	**Yes.** Same as Basic.	**Yes.** Same as Basic.	**Yes.** Same as Basic.
1. **PROVIDING MEDICAL INFORMATION:** Approval of Request for Insurance (SF 2822) by the Office of Federal Employees' Group Life Insurance (OFEGLI).	**Yes. Coverage** is automatically effective the first day the employee is in a pay and duty status on or after date of OFEGLI's approval. **Time Limit** - on or after OFEGLI's date of approval. If employee is not in a pay and duty status within 60 days, Basic does ***NOT*** become effective, and the employee must start over.	**Yes. Coverage** is effective the first day the employee is in a pay and duty status on or after the date of OFEGLI's approval **and** the agency receives the SF 2817. **Time Limit -** Employee must submit the SF 2817 and be in a pay and duty status within 60 days after date of OFEGLI's approval. If employee is not in a pay and duty status or doesn't submit the SF 2817 within those 60 days, Option A does **not** become effective, and the employee must start over.	**Yes.** Same as Option A.	**No.** An employee may ***NOT*** elect Option C by providing medical information.
2. **LIFE EVENT:** Marriage, divorce, death of spouse, or acquisition of an eligible child.	**Yes. Coverage** is effective the day of the event if the SF 2817 is received ***before the event*** and the employee is in pay and duty status ***on the day of the event***. Otherwise, **Coverage** is effective the first day in pay and duty status ***after*** the event and ***after*** receipt of the SF 2817. **Time Limit** - Agency must receive the SF 2817 and proof of the event within 60 days after the day of the event.	**Yes.** Same as Basic. **Coverage** - Same as Basic. **Time Limit** - Same as Basic.	**Yes**. Same as Basic. Employee may elect or increase multiples (up to 5 total). **Coverage -** Same as Basic. **Time Limit** - Same as Basic.	**Yes**. Employee may elect or increase multiples (up to 5 total). If the employee has Basic, **Coverage** is effective the day the employing office receives the election, or the date of the event, whichever is later. If Basic and Option C are elected at the same time, Option C is effective when Basic becomes effective. **Time Limit** - Same as Basic. (Note: If the employee already has Basic, there is no pay and duty status requirement for Option C.)
3. **REINSTATEMENT:** Employee is reinstated after a break in service of at least 180 days in a position that is ***not excluded*** from life insurance by law or regulation.	**Yes. Coverage** is effective on the first day the employee is in a pay and duty status, unless waived by employee.	**Yes.** Employee may elect Option A within 60 days after reinstatement. ***However, if employee does not submit SF 2817 electing coverage within 60 days after reinstatement, s/he has the same Optional insurance carried before the break in service effective the beginning of the reinstatement.***	Same as Option A.	Same as Option A.
4. **REINSTATEMENT:** Employee is reinstated after a break in service of at least 180 days in a position that ***is excluded*** from life insurance by law or regulation.	**No.** However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is in a pay and duty status on or after being converted to such a position.	**No.** However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is in a pay and duty status in the converted position on or after the date the agency receives the SF 2817 electing such coverage. **Time Limit -** Employee must submit the SF 2817 within 60 days after conversion to an eligible position.	Same as Option A.	Same as Option A.
5A. **CANCELING/ WAIVING COVERAGE:** employee/assignee or	A. **Yes.** If the coverage is canceled in the first pay period, no premiums are due. Otherwise, coverage stops at the end of the last day of the pay period in which the agency receives the SF 2817, with **no** 31-day extension of coverage. **Time Limit -** None. Employee may cancel coverage at any time. However, if the insurance is assigned, only the assignee(s) may cancel	A. Same as Basic.	A. Same as Basic.	A. Same as Basic. Option C cannot be assigned. If Option C is canceled because there no longer are eligible family members, the effective date is retroactive to the end of the pay period in which there no longer are any eligible family members. The employing agency must refund Option C premiums retroactive to that effective date.
5B. **REDUCING OPTION B and/or OPTION C MULTIPLES**: employee/assignee	B. Not applicable.	B. Not applicable.	B. **Yes**. Employee may at any time reduce the number of multiples, unless the insurance has been assigned. In that case, only the assignee(s) may reduce coverage – the employee may not. This new coverage is effective at the beginning of the pay period following the one in which the employing office receives the SF 2817.	B. **Yes**. Employee may at any time reduce the number of multiples. This new coverage is effective at the beginning of the pay period following the one in which the employing office receives the SF 2817. Assignee(s) cannot reduce Option C.
6. Open Season.	If permitted under conditions specified by OPM.	Same as Basic.	Same as Basic.	Same as Basic.
7. **CERTAIN DEPT. OF DEFENSE AND CIVILIAN EMPLOYEES AFFECTED BY PUBLIC LAWS 106-398 AND 110-417:**	**Yes,** if employing agency determines employee meets criteria to elect coverage. Coverage is effective the first day the employee is in a pay and duty status on or after the date the agency receives the SF 2817. **Time Limit -** Agency must receive the SF 2817 within 60 days of the date the employee receives official notice of deployment in support of a contingency operation or designation as an emergency essential employee.	Same as Basic. For Information Only	Same as Basic. Employee may elect or increase multiples (up to 5 total).	**No.** An employee may ***NOT*** elect Option C via these provisions of law.

Instructions for Employees

1. General Information
The major provisions of this program are described in the *Federal Employees' Group Life Insurance (FEGLI) Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees). Please read the entire booklet carefully. Your completed copy of this election form (SF 2817) and the FEGLI Program Booklet constitute your certificate (proof) of insurance. These publications, as well as comprehensive FEGLI information, are available at *www.opm.gov/insure/life*.

2. I Am A New Employee or Newly Eligible for Life Insurance. What Do I Need To Know?
You are automatically enrolled in Basic (even if you don't complete this form) unless you waive it. If you waive Basic, you automatically waive all forms of Optional insurance. You will not have any Optional insurance unless you elect it.

To elect Basic: You do not have to submit this form unless you also wish to elect Optional insurance.

To waive Basic: Sign Section 5 of the form and give it to your employing office. Your agency will withhold Basic premiums from your salary from your first day at work in a pay status UNLESS you submit your waiver before the end of your first pay period.

To elect Optional: Sign Section 3 and one or more of the blocks in Section 4 of the form and give it to your employing office within 60 days after the date you are appointed or first become eligible for life insurance.

To waive Optional: If you do not sign for a particular type of Optional coverage in Section 4, ***you automatically waive that coverage***.

3. I Am An Employee With Prior Government Service. What Do I Need To Know?
When you return to work after a break in service of ***less than 180 days***, your human resources office will automatically enroll you in the same coverage that you had before you left your prior position, if any. This coverage will be effective on your first day in a pay and duty status in a FEGLI eligible position. You will have to qualify to elect other coverage (open season, providing medical information, or a life event). If you waived some coverage, then the waiver of that coverage is still in effect.

When you return to work after a break in service of ***180 days or more***, your human resources office will automatically enroll you in Basic and the same Optional insurance that you had in your prior position. This coverage will be effective on your first day in a pay and duty status in a FEGLI eligible position. You may elect more insurance (if you don't already have the maximum) within 60 days of your appointment to an eligible position. If you previously waived coverage then that waiver is no longer in effect. You will automatically be enrolled in Basic, unless you file a new waiver.

See the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service Employees) for more details.

4. I Am A Reemployed Annuitant. What Do I Need To Know?
If you waive your insurance when you return to Federal Service as a reemployed annuitant, you also waive your insurance with your retirement annuity. You will have no FEGLI life insurance. It is important that you contact your human resources office and inform them that you are a reemployed annuitant. More details can be found in OPM Form 1482, *Agency Certification of Status of Reemployed Annuitants*.

5. What If I Assigned My Coverage?
If you have assigned your insurance by filing an RI 76-10, *Assignment of Federal Employees' Group Life Insurance*, you may not cancel any of your insurance coverage (except Option C). Only the assignee(s) may cancel your coverage. However, you may elect new coverage if you otherwise meet the requirements for electing such coverage. Any new coverage you elect will automatically be subject to your existing assignment, except for Option C, which you cannot assign. All assignments are automatically canceled after a break in service of at least 31 days, or upon cancellation of all life insurance coverage by the assignee(s).

6. I Am An Assignee. What Can I Do?
If you are completing this form in order to cancel some or all of the employee's life insurance coverage, you must sign the form. The information in Section 2 of the form refers to the employee, but you must sign in Section 3, 4 or 5, as applicable. Indicate "assignee" after your signature. Return the completed form to the employee's employing office. If the insured is an annuitant, return the completed form to OPM, Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045. See #11 for where to return the completed form if the insured is a compensationer.

7. How Do I Complete The Form?
Follow the instructions for each item carefully. After you fill out the form, review it to be sure it is complete and correct. The following checklist should help.

If you sign Section 3, you elect (or retain) **Basic**.

If you sign any block in Section 4, you elect (or retain) **Optional Insurance**. You must also elect (or retain) Basic by signing Section 3.

If you sign Section 4 for Option B and/or Option C, you must also mark one of the five boxes to show how many multiples you wish to elect (or retain). Do not mark more than one box.

Be Sure You Sign For All Options You Want. This election supersedes all previous ones. If you have optional coverage and wish to keep it, you must sign the appropriate box(es). If you do not sign for it, you have waived it.

If you sign Section 5, you waive all FEGLI coverage.

Only you, the employee, may sign this form. Signatures by guardians, conservators, or through a power of attorney are not acceptable.
Exception: If you have assigned your insurance, only the assignee(s) may cancel some or all of your coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to you).

REMEMBER THAT YOU, NOT YOUR AGENCY, ARE RESPONSIBLE FOR ENSURING THAT YOUR SF 2817 *(OR ITS ELECTRONIC EQUIVALENT)* IS CORRECT AND ACCURATELY REFLECTS YOUR INTENTIONS. IF YOU DO NOT SIGN FOR IT, YOU HAVE CANCELED/WAIVED IT.

8. Open Seasons
If you elected coverage during an Open Season, and that coverage has not yet become effective, and you want to make a further change to your FEGLI coverage on this SF 2817, you should check with your employing office. That office can tell you about any special election procedures that may apply.

9. What If I Waive or Reduce My Coverage?
If you do not sign for a particular type of coverage, you have waived that coverage. If you waive Basic or one or more of the options, your opportunities to enroll in the coverage you waived are strictly limited. A waiver may also affect your eligibility to continue coverage into retirement. See the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) for more details.

10. Where Do I Send The Completed Form?
After you have completed this form and verified that it accurately reflects your intentions, send the entire form (without separating the parts) to your human resources office. Do ***not*** send the form to OPM or OFEGLI.

11. What If I Receive Workers' Compensation?
If you are receiving compensation payments from the Office of Workers' Compensation Programs (OWCP), provide your OWCP number in Section 2 of the form. If you are still employed, return the completed form to your employing office. If you are not still employed or if you have been receiving compensation payments for at least 12 months, see your human resources office about your continued eligibility under the FEGLI Program.

12. How Do I Verify That My Agency Processed My Election?
After your employing office processes your election form, you will receive an SF 50, *Notification of Personnel Action*. A two digit code appearing on the SF 50 will explain your insurance coverage. These codes are explained in Part 2 of the SF 2817. Also check your pay statement for the correct withholdings. If you are insured as a compensationer, you will receive a notice from OPM which will explain your insurance coverage.

13. Where Do I Get More Information About The FEGLI Program?
Consult the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) or the *FEGLI Handbook* (RI 76-26), which are available on the FEGLI web site at *www.opm.gov/insure/life*.

For Information Only

Privacy Act and Public Burden Statements

Chapter 87, title 5, U.S. Code, Federal Employees' Group Life Insurance, authorizes solicitation of this information. The data you furnish will be used to determine your life insurance coverage. This information may be shared and is subject to verification, via paper, electronic media, or through the use of the computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs or law enforcement agencies, when they are investigating a violation or potential violation of civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number to distinguish between the applicant and people with similar names. Failure to furnish the requested information may result in your agency's inability to determine your life insurance coverage.

We estimate this form takes an average of 15 minutes to complete including the time for getting the needed data and reviewing both the instructions and completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management (OPM), Retirement Services Publications Team (3206-0230), Washington, DC 20415-3430. The OMB Number, 3206-0230 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.