Daniel P. Beard
Chief Administrative Officer

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

Clear form

Print ALL pages, including instructions

Print REQUIRED & completed optional pages, NO instructions

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

This page is intended to facilitate the completion of payroll forms using the Adobe Reader. The personal information entered on this page will propagate into corresponding fields on the following forms. We strongly recommend using Adobe Reader to complete the forms because you will have the option to print all of the pages or only the ones required for the On-Boarding process. If you choose to hand write the required forms, you may discard all sheets marked “For Information Only” at the bottom of each sheet.

All pages through page 17 are required to complete the On-Boarding process. Pages 18-29 are supplemental benefit forms that you do not need to complete on date of hire.

Name
First Middle Last

Social Security Number — When entering your SSN, please enter the dashes, i.e. 123-45-6789.

Date of Birth — When entering the date, you must type in the slash "/" or put a space between the numbers, i.e. MM DD YYYY or 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

When entering phone numbers, use numbers only, do not use (, spaces or dashes

Employing Office Name

Today’s date or Effective date of forms — Please enter the date in format MM/DD/YYYY

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

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

Form I-9, Employment Eligibility Verification

Instructions

Please 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 U.S.) 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 eligible 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.

What Is the Purpose of This Form?

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

When Should the Form I-9 Be Used?

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

Filling Out the Form I-9

Section 1, Employee: This part of the form must be completed at 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.**

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/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 eligibility within three (3) business days of the date employment begins. If employees are authorized to work, but are unable to present the required document(s) within three business days, they must present a receipt for the application of the document(s) within three business days and the actual document(s) within ninety (90) days. However, if employers hire individuals for a duration of less than three business days, **Section 2** must be completed at the time employment begins. **Employers must record:**

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. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. These photocopies may only be used for the verification process and must be retained with the Form I-9. **However, employers are still responsible for completing and retaining the Form I-9.**

Section 3, Updating and Reverification: Employers must complete **Section 3** when updating and/or reverifying the Form I-9. Employers must reverify employment eligibility of their employees on or before the expiration date recorded in **Section 1**. 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 (3) years of the date this form was originally completed and the employee is still eligible 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 (3) 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 that the employee is authorized to work in the U.S. (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.

What Is the Filing Fee?

There is no associated filing fee for completing the Form I-9. This form is not filed with USCIS or any government agency. The 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, call our toll-free number at **1-800-870-3676**. Individuals can also get USCIS forms and information on immigration laws, regulations and procedures by telephoning our National Customer Service Center at **1-800-375-5283** or visiting our internet website at **www.uscis.gov**.

Photocopying and Retaining the 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 Forms I-9 for three (3) years after the date of hire or one (1) year after the date employment ends, whichever is later.

The 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 officials of U.S. Immigration and Customs Enforcement, 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.

Paperwork Reduction Act

We try to create forms and instructions that are accurate, can be easily understood and which impose the least possible burden on you to provide us with information. Often this is difficult because some immigration laws are very complex. Accordingly, the reporting burden for this collection of information is computed as follows: **1)** learning about this form, and completing the form, 9 minutes; **2)** assembling and filing (recordkeeping) the form, 3 minutes, for an average of 12 minutes per response. If you have comments regarding the accuracy of this burden estimate, or suggestions for making this form simpler, you can write to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529. OMB No. 1615-0047.

OMB No. 1615-0047; Expires 06/30/08

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

Form I-9, Employment Eligibility Verification

Please 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 eligible 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 or national of the United States
- ☐ A lawful permanent resident (Alien #) A _____
- ☐ An alien authorized to work until _____

(Alien # or Admission #) _____

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

Section 3. Updating and Reverification. To be completed and signed by employer.

SKIP THIS SECTION

LISTS OF ACCEPTABLE DOCUMENTS

LIST A **Documents that Establish Both Identity and Employment Eligibility**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Eligibility**
1. U.S. Passport (unexpired or expired)		**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.** U.S. Social Security card issued by the Social Security Administration *(other than a card stating it is not valid for employment)*
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color and address		**2.** Certification of Birth Abroad issued by the Department of State *(Form FS-545 or Form DS-1350)*
3. An unexpired foreign passport with a temporary I-551 stamp		**3.** School ID card with a photograph		**3.** Original or certified copy of a birth certificate issued by a state, county, municipal authority or outlying possession of the United States bearing an official seal
4. An unexpired Employment Authorization Document that contains a photograph (Form I-766, I-688, I-688A, I-688B)		**4.** Voter's registration card		**4.** Native American tribal document
		5. U.S. Military card or draft record		**5.** U.S. Citizen ID Card *(Form I-197)*
5. An unexpired foreign passport with an unexpired Arrival-Departure Record, Form I-94, bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, if that status authorizes the alien to work for the employer		**6.** Military dependent's ID card		**6.** ID Card for use of Resident Citizen in the United States *(Form I-179)*
		7. U.S. Coast Guard Merchant Mariner Card		
		8. Native American tribal document		**7.** Unexpired employment authorization document issued by DHS *(other than those listed under List A)*
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor or hospital record		
		12. Day-care or nursery school record		

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 31 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

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 10.

Form W-4 (2009)

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 2009 expires February 16, 2010. See Pub. 505, Tax Withholding and Estimated Tax.

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

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-earner/multiple job 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 may 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. 919, How Do I Adjust My Tax Withholding, 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. 919 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. 919 for details.

Nonresident alien. If you are a nonresident alien, see the Instructions for Form 8233 before completing this Form W-4.

Check your withholding. After your Form W-4 takes effect, use Pub. 919 to see how the amount you are having withheld compares to your projected total tax for 2009. See Pub. 919, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

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 $1,800 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 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 plus "1" **additional** if you have six or more eligible children.	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 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 ($25,000 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.

Cut here and give Form W-4 to your employer. Keep the top part for your records.

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

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2009

1 Type or print 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 2009, 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 10.

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions, claim certain credits, adjustments to income, or an additional standard deduction.

1 Enter an estimate of your 2009 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. (For 2009, you may have to reduce your itemized deductions if your income is over $166,800 ($83,400 if married filing separately). See *Worksheet 2* in Pub. 919 for details.) . . 1 $

2 Enter: { $11,400 if married filing jointly or qualifying widow(er) / $ 8,350 if head of household / $ 5,700 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 2009 adjustments to income and any additional standard deduction. (Pub. 919) . . . . . 4 $

5 **Add** lines 3 and 4 and enter the total. (Include any amount for credits from *Worksheet 8* in Pub. 919.) . 5 $

6 Enter an estimate of your 2009 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 $3,500 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 $50,000 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 4–9 below to calculate 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 2009. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2008. 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

If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $4,500	0
4,501 - 9,000	1
9,001 - 18,000	2
18,001 - 22,000	3
22,001 - 26,000	4
26,001 - 32,000	5
32,001 - 38,000	6
38,001 - 46,000	7
46,001 - 55,000	8
55,001 - 60,000	9
60,001 - 65,000	10
65,001 - 75,000	11
75,001 - 95,000	12
95,001 - 105,000	13
105,001 - 120,000	14
120,001 and over	15

All Others

If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0
6,001 - 12,000	1
12,001 - 19,000	2
19,001 - 26,000	3
26,001 - 35,000	4
35,001 - 50,000	5
50,001 - 65,000	6
65,001 - 80,000	7
80,001 - 90,000	8
90,001 - 120,000	9
120,001 and over	10

Table 2

Married Filing Jointly

If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $65,000	$550
65,001 - 120,000	910
120,001 - 185,000	1,020
185,001 - 330,000	1,200
330,001 and over	1,280

All Others

If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $35,000	$550
35,001 - 90,000	910
90,001 - 165,000	1,020
165,001 - 370,000	1,200
370,001 and over	1,280

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 10.

Employee's Withholding Allowance Certificate
2009 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 2009 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: _____, _____, _____

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%) ☐

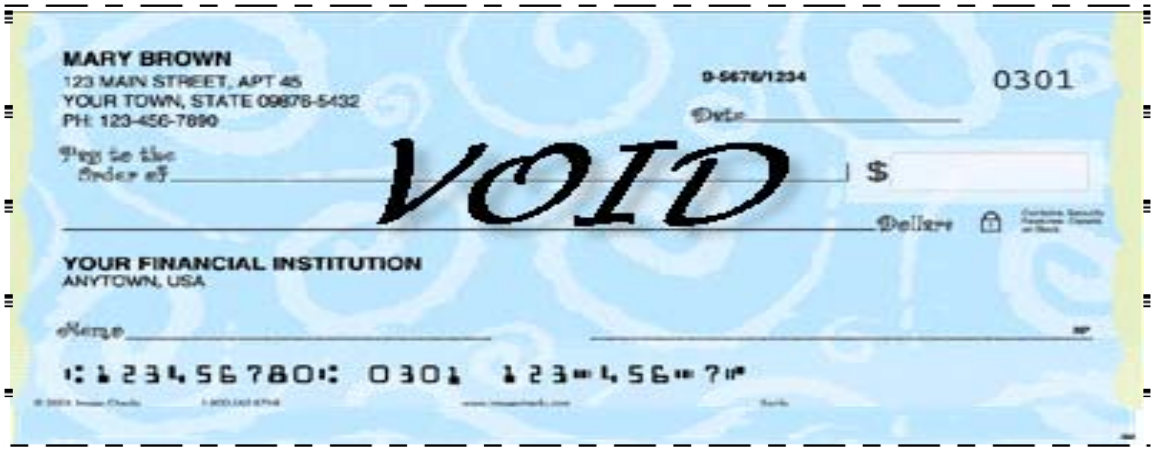
Financial Institution Name: _____

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 **$** ☐

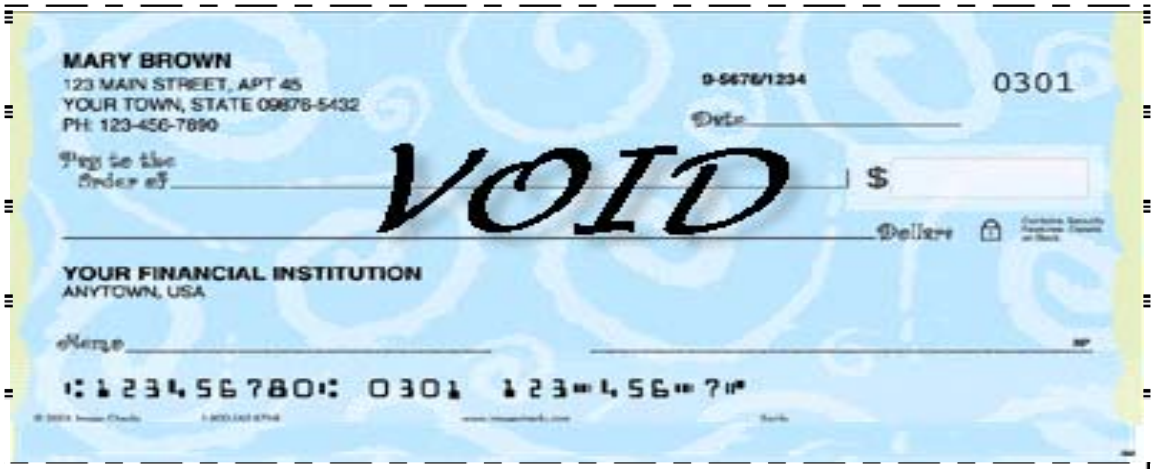
Financial Institution Name: _____

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: _____

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: _____

This form is not used in all offices or committees. The employee should present this form to their hiring office to determine if the form is required.

UNITED STATES CAPITOL POLICE
WASHINGTON, D.C. 20510-7218

CP-491
(4-04)

REQUEST FOR CHECK OF CRIMINAL HISTORY RECORDS

Please report with: (1) A valid form of photo identification, (2) and this form to the Fairchild Building Located at 499 South Capitol Street SW Washington, D.C., Room 127 between the hours of 7am until 3pm Monday through Friday for processing.

1. *Name*: (Last, First, Middle)

, ,

Address:

Street & No. '

City & State:

Select you

Zip: Tele:

Home Daytime

2. *Other Names Ever Used:* (e.g. maiden name. nickname, etc. If you have never used another name write "None".)

3. *Date of Birth:* (Month, Day, Year)

4. *Birthplace:* (City and State or Country)

5. *Social Security Number:*

6. *Gender:* Male ☐ Female ☐

7. *Race:* **8**. *Height:* **9**. *Weight:* **10**. *Eye Color:* **11**. *Hair Color:*

SIGNATURE AND RELEASE OF INFORMATION:

READ THE FOLLOWING CAREFULLY BEFORE YOU SIGN:

- I understand that the information provided above will be used to check the criminal history records of the Federal Bureau of Investigation (FBI).
- I consent to the use of the information provided in making a security determination concerning me.
- I certify that, to the best of my knowledge and belief, all of the information provided above is true, correct, and complete, made in good faith.

12. Signature **13**. Date:

Print ALL pages, including instructions

Print REQUIRED & completed optional pages, NO instructions

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-1	May enroll at any time.
TSP	TSP-1C	May enroll at any time.
Health	SF-2809	Within 60 days of your appointment.
Life	SF-2817	Within 31 days of your appointment.

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.**

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

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

II. START OR CHANGE YOUR CONTRIBUTIONS

To start or change the amount of your contributions to your TSP account, enter **either** a whole percentage of your basic pay per pay period (Item 6) **or** a whole dollar amount per pay period (Item 7). Skip to Section IV.

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

6. _____.0% **OR** **7.** $ _____.00

III. STOP YOUR CONTRIBUTIONS

To stop your contributions to the TSP, check Item 8 and complete Section IV. (If you are a FERS employee and you are eligible to receive Agency Automatic (1%) Contributions, those 1% contributions will continue. Read the instructions on the back.)

8. ☐ I want to stop contributing to my TSP account. I understand that my payroll contributions will stop no later than the first full pay period after my agency employing office receives this form.

IV. SIGNATURE

9. _____ **10.** ___/___/___
Participant's Signature Date Signed *(mm/dd/yyyy)*

V. FOR EMPLOYING OFFICE USE ONLY

11. 00004832 **12.** ___/___/___ **13.** ___/___/___
Payroll Office Number Receipt Date *(mm/dd/yyyy)* Effective Date *(mm/dd/yyyy)*

14. _____
Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request this information under 5 U.S.C. chapter 84. Executive Order 9397 authorizes us to ask for your Social Security number, which will be used to identify your account. We will use the information you provide on this form to process your TSP election. This information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. In addition, we may share the information 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. We may also disclose relevant portions of the information to appropriate parties engaged in litigation. You are not required by law to provide this information, but if you do not provide it, we will not be able to process your request.

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

This completed form may be faxed to 202-225-5969

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

Form TSP-1 (5/2007)
EDITIONS PRIOR TO 1/06 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 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 Plan Summary 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 Web site at www.tsp.gov.)

To choose your investment fund(s), use the TSP Web site (www.tsp.gov), the ThriftLine at 1-877-968-3778 (outside the U.S. and Canada, call 404-233-4400), or Form TSP-50, Investment Allocation. If you use the ThriftLine, you will need your Social Security number (SSN) and your 4-digit ThriftLine Personal Identification Number (PIN). If you use the TSP Web site, you will need your SSN and 8-character Web password. If you are a new participant, your ThriftLine PIN and your Web password will be mailed to you (separately) after your account has been established. If, as a new participant, you choose to submit Form TSP-50, do **not** do so until you receive a letter from the TSP confirming that your new account has been established. If your account has not been established, Form TSP-50 will not be accepted.

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

SECTION I

Complete all items in this section.

SECTION II

Complete this section to start your TSP contributions or to change the amount you are contributing to the TSP. Complete **either** Item 6 **or** Item 7.

Item 6, Percentage of Basic Pay per Pay Period. You may contribute up to the Internal Revenue Code (IRC) annual elective deferral limit (e.g., $15,500 in 2007). If you specify a percentage, your contribution amount will automatically increase when you receive a pay raise.

Item 7, Dollar Amount per Pay Period. The dollar amount you contribute cannot exceed the annual elective deferral limit for the year. You can contribute as little as $1 per pay period. If you specify a dollar amount, it will not change until you submit a new Form TSP-1.

SECTION III

Complete this section to stop your contributions. You may restart your contributions at any time.

Note: If you are a FERS employee, you may change the way your Agency Automatic (1%) Contributions are invested even if you are not contributing to your account. You can use the TSP Web site, the ThriftLine, or Form TSP-50, as described in "General Information" above.

SECTION IV

You must complete this section.

SECTION V

(To be completed by personnel or benefits office)

In Item 12, enter the receipt date. This 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.

In Item 13, enter the effective date of the election. Elections should be made effective no later than the first full pay period after receipt of a properly completed form.

THRIFT SAVINGS PLAN
CATCH-UP CONTRIBUTION ELECTION

TSP-1-C

Use this form to start, stop, or change your election to make "catch-up" contributions 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 IRS 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; 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.**

Note: Your catch-up contributions will be invested according to your most recent contribution allocation. (See instructions on the back.)

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. START OR CHANGE YOUR CATCH-UP CONTRIBUTIONS

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

To start or change your catch-up contributions, complete Items 6, 7, and 8. Use a whole dollar amount. (See additional instructions on the back of the form.)

6. ☐ I elect to contribute $_____.00 per pay period. This 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 YOUR CATCH-UP CONTRIBUTIONS

To stop your contributions, complete Items 9, 10, and 11.

9. ☐ I want to stop making catch-up contributions to my TSP account. I understand that I must make a new election to resume these contributions.

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. We will use this information to identify your TSP account and to process this form. In addition, this information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. We may share the information 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. We may disclose relevant portions of the information 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, we will not be able to process your request.

This completed form may be faxed to 202-225-5969

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

Form TSP-1-C (4/2008)
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 (according to TSP and/or IRS elective deferral limits) 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. If you wish to change your contribution allocation, you may do so on the TSP Web site at www.tsp.gov, the ThriftLine at 1-TSP-YOU-FRST (1-877-968-3778; outside the U.S. and Canada, call 404-233-4400), or Form TSP-50, Investment Allocation.

SECTION I

Complete all items in this section.

SECTION II

The IRS limit for catch-up contributions is **$5,000 in 2008**. Thereafter, the amount may be adjusted for inflation. Check the TSP Web site, www.tsp.gov, for updated information.

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 make 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 or your request to start or change your catch-up contributions will be rejected.

SECTION III

If you choose to stop 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.

SECTION IV

In Item 13, enter the receipt date. This 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.

In Item 14, enter the effective date of the election. Elections should be made effective 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 for his or her records.

FEHB
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 and attach.)*

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

2. Social Security Number

3. Date of birth

4. Sex ☐ M ☐ F

5. Are you married? ☐ Yes ☐ No

6. Home Mailing Address *(including ZIP Code)*
,
, Select your state,

7. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D

8. TRICARE ☐

9. Other insurance ☐

10. Name of Insurance

11. Insurance policy no.

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

13. Social Security Number

14. Date of birth

15. Sex ☐ M ☐ F

16. Relationship code

17. Address *(if different from enrollee)*

18. Medicare *(See note - page 2)* ☐ A ☐ B ☐ D

19. TRICARE ☐

20. Other insurance ☐

21. Name of Insurance

22. Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of Insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of Insurance | Insurance policy no.

Name of family member *(last, first, middle initial)* | Social Security Number | Date of birth | Sex ☐ M ☐ F | Relationship code

Address *(if different from enrollee)* | Medicare *(See note - page 2)* ☐ A ☐ B ☐ D | TRICARE ☐ | Other insurance ☐

Name of Insurance | Insurance policy no.

Part B - Present Plan

1. Plan name
2. Enrollment code

Part C - New Plan

1. Plan name
2. Enrollment code

Part D - Event Code

1. Event code
2. Date of event

Part E - Employees Only (Election NOT to Enroll)

☐ 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

☐ 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 (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. Daytime telephone number

Part I -To be completed by agency or retirement system

REMARKS

1. Date received
2. Effective date of action
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) elect Basic and any or all of the options, (2) elect Basic but waive 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.
- Do not separate the parts. Give this form to your employing office which will complete the form 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 employee works *(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 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 Postal Service employees.)

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* ➡ | 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 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

I want Option A.
I authorize deductions to pay the full cost.

☐

Clear Life Options

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* ➡

Date *(mm/dd/yyyy)*

Option B - Additional

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

Signature *(Do not print. Only the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* ➡

Date *(mm/dd/yyyy)*

Option C - Family

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 the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* ➡

Date *(mm/dd/yyyy)*

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 results of a physical, or (2) I have a break in Federal service of at least 180 days, or (3) I participate in an open enrollment period, 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 the Employee/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* ➡ | Date *(mm/dd/yyyy)*

6 Agency Use Remarks:

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 booklet (RI 76-21 or RI 76-20 for Postal Service employees) constitute the employee's Certificate of Insurance.

PART 1 - File in Official Personnel Folder

Instructions for Agencies

1. Who Should File This Form

- New employees eligible for life insurance.
- 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 insurance.
- Reinstated employees who filed a previous waiver of any type of life insurance and who were separated from service for at least 180 days.

Give a new employee a copy of the FEGLI booklet (RI 76-21 or RI 76-20 for 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 31 days after his or her appointment.

Employees with prior service in nonexcluded positions who were separated after March 31, 1981, will 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 in the employee's *Declaration for Federal Employment*, OF 306, if completed.

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).

An employee may elect or increase Basic, Option A, or Option B insurance (but **not** Option C), if a signed waiver has been in effect for more than one year, by submitting a *Request for Insurance*, SF 2822. If approved, ask the employee to submit an SF 2817 showing his or her election. More details are contained on the SF 2822.

An employee who is already enrolled in Basic may elect Option B and/or Option C within 60 days following marriage, divorce, spouse's death, or the acquisition of an eligible child. **Exception:** Acquiring a foster child does not count as a life event for Option B purposes.

- For Option B, the number of multiples he or she may elect (up to 5 total) is limited to the following: (a) for marriage or acquisition of a child, the number of additional family members; (b) for divorce or death of spouse, the total number of the employee's dependent children.
- For Option C, he or she may elect from 1 to 5 multiples (up to 5 total) no matter how many family members he/she has or acquires with the event.

An employee who is already enrolled in Option B and/or Option C for at least one multiple may change to a higher multiple within 60 days following marriage, divorce, spouse's death, or the acquisition of an eligible child. The number of multiples is limited as listed above.

2. Review of Completed Form

Review the original and both copies 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 item 3, Basic.

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

Exception: If the employee assigned his or her insurance, only the assignee(s) may ***waive*** 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.

Instruct the employee that, while the agency will make sure that the SF 2817 is complete, he or she is solely responsible for ensuring that the SF 2817 accurately reflects his or her intentions.

3. Completion of Form

The Personnel Officer or his or her designated representative must confirm that the employee is eligible for the coverage that he or she has elected and sign the form in item 6.

4. Date Received

Enter the date the employing office received this form.

5. Number of Event Permitting 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. Effective Date of Coverage

Enter the effective date of coverage. For new and newly eligible employees: Basic is effective on the first day the employee is at work in a pay status; Optional coverage is effective on the first day the employee is at work in a pay 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 the employee elected more than one type of coverage and there is more than one effective date, write in both dates and provide details in the Remarks section.

7. Disposition of SF 2817

After completion, remove Part 3 and return it to the employee. File Part 1 in the employee's personnel folder. Destroy Part 2 after payroll office use.

8. Further Information

For further information, consult the FEGLI Handbook (RI 76-26) or the FEGLI Booklet (RI 76-21 or RI 76-20 for Postal Service employees), 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 Election

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

Event Allowing Change	Change Permitted? *(To enroll in any option, employee must enroll or be enrolled in Basic)*			
	Basic	**Option A - Standard**	**Option B - Additional**	**Option C - Family**
1. Physical: Approval of Request for Insurance (SF 2822) by the Office of Federal Employees' Group Life Insurance (OFEGLI).	**Yes. Coverage** is effective on the first day the employee is at work in a pay status after date of OFEGLI's approval. **Time Limit** - OFEGLI's approval expires after 31 days. If employee is not at work in a pay status within those 31 days, Basic does **not** become effective. Employee must obtain a new physical.	**Yes. Coverage** is effective on the first day the employee is at work in a pay status on or after date of OFEGLI's approval **and** agency receives the SF 2817. **Time Limit** - Employee must submit SF 2817 and be at work in a pay status within 31 days after date of OFEGLI's approval. If employee is not at work in a pay status or doesn't submit the SF 2817 within those 31 days, Option A does **not** become effective. Employee must obtain a new physical.	Same as Option A.	No change permitted for this event.
2. Life Event: Marriage, divorce, death of spouse or acquisition of an eligible child.	No change permitted for this event.	No change permitted for this event.	**Yes**. Employee may elect or increase multiples (limited to 5 total) up to (a) for marriage or children, the number of additional family members; (b) for divorce or death of spouse, the total number of dependent children. **Exception:** Acquiring a foster child does not count as a life event for Option B purposes. **Coverage** is effective the day of the event (**IF** employee is at work in a pay status on that day), if employee submits the SF 2817 **before** the event. **Coverage** is effective the first day the employee is at work in a pay status on or after the date of the event, if employee submits the SF 2817 within 60 days **after** the event (or is not at work in a pay status on the day of the event). **Time Limit** - Agency must receive SF 2817 and proof of the event within 60 days after date of event. (Time limit may be extended if event occurs when employee was separated from Federal service or if it occurs 60 days or less before separation.)	Yes. Employee may elect or increase multiples (limited to 5 total) no matter how many family members he/she has or acquires with the event. **Coverage** is effective the day of the event, if employee submits the SF 2817 **before** the event. **Coverage** is effective the day the agency receives the SF 2817, if employee submits it within 60 days **after** the event. **Time Limit** - Agency must receive SF 2817 and proof of the event within 60 days after date of event. (Time limit may be extended if event occurs when employee was separated from Federal service, 60 days or less before separation, or during the year following waiver of Basic.)
3. 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 at work in a pay status, if no new waiver is filed.	**Yes.** Employee may elect any or all optional insurance within 31 days after reinstatement. **Coverage** is the same as with new employees. However, if employee does not submit SF 2817 electing such coverage to his/her agency within 31 days after reinstatement, he/she has the same Optional insurance carried immediately before his/her break in service.	Same as Option A.	Same as Option A.
4. Employee returns to Federal Service 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 at work in a pay 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 converted to such a position wherein he or she is at work in a pay status on or after the date the agency receives the SF 2817 electing such coverage. **Time Limit** - Employee must submit SF 2817 electing such coverage to his or her agency within 31 days after conversion.	Same as Option A.	Same as Option A.
5A. Employee initially waives or subsequently cancels life insurance coverage. or 5B. Employee (or if applicable, assignee(s)) elects to decrease optional coverage.	A. **Yes. 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 coverage – the employee may not. B. Not applicable.	A. Same as Basic. B. Not applicable.	A. Same as Basic. 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. **Coverage** reduces effective on the last day of the pay period in which the agency receives the SF 2817.	A. Same as Basic, except information on assignment is not applicable. B. **Yes**. Employee may at any time reduce the number of multiples. **Coverage** reduces effective on the last day of the pay period in which the agency receives the SF 2817.
6. Open Enrollment Period.	If permitted under conditions specified by OPM.	Same as Basic.	Same as Basic.	Same as Basic.

For Information Only

Instructions for Employees

1. General Information

The major provisions of this program are described in the *Federal Employees' Group Life Insurance (FEGLI)* booklet (RI 76-21 or RI 76-20 for Postal Service employees, available from your employing office). Please read the entire booklet carefully. Your completed copy of this election form and the FEGLI booklet constitute your certification of coverage.

2. New Employees and Employees Newly Eligible for Life Insurance

You are automatically enrolled in Basic 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 need to submit this form unless you also wish to elect Optional insurance. If you do not submit this form, you will have Basic, but no Optional coverage.

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 31 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. If you do not submit the form at all, you will have Basic, but no Optional coverage.

3. Employees With Prior Government Service

A life insurance election or waiver on SF 2817 filed during a prior period of Federal employment stays in effect unless you change coverage or have a break in service of at least 180 days.

A break in service of at least 180 days cancels any previous waiver of insurance. Unless you file a new waiver, Basic becomes effective on the first day you actually enter on duty in a pay status in a position in which you are eligible for coverage. You can elect any amount of Optional insurance within 31 days of returning to service, regardless of the coverage you had during previous employment. If you fail to elect any Optional insurance, you will automatically get the Optional insurance you carried immediately before your break in service.

If you had a break in service of less than 180 days and were eligible in your last period of Federal employment, your life insurance in your new employment will be the same as you had then and if you waived coverage then, the waiver is still in effect. Your opportunities to cancel your waiver are strictly limited. See the FEGLI booklet.

4. Reemployed Annuitants

If you waive your insurance as a reemployed annuitant, you also waive your insurance as an annuitant, and you will have no Federal life insurance.

5. Assignment

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 current insurance coverage. 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. Attention Assignees

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 to Complete and Review Your Election 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 item 3, you elect (or retain) **Basic**. Do not also sign item 5. (You cannot elect (or retain) **and** waive coverage.)

If you sign any block in item 4, you must also sign item 3. (To elect (or retain) an option, you must also elect (or retain) Basic.)

If you sign item 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.

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 item 5, you waive Basic. Do not sign item 3 or any block in item 4. (You cannot waive **and** elect 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 IS CORRECT AND ACCURATELY REFLECTS YOUR INTENTIONS.

8. 1999 Open Enrollment Period

If you elected coverage during the 1999 Open Enrollment Period, 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. Waiving or Changing Your Insurance 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 booklet.

10. Where to Send 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 employing office.

11. Compensationers

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, return the completed form to OPM, Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045.

12. How to Verify that Your Agency Processed Your Election

After your employing office processes your election form, you will receive an SF 50, *Notice of Personnel Action*. A two digit code appearing on the SF 50 will explain your insurance coverage. These codes are explained on 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. Further Information

For further information, consult the *FEGLI Handbook* (RI 76-26) or the *FEGLI Booklet* (RI 76-21 or RI 76-20 for Postal Service employees), 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 the civil or criminal law. Public Law 104-134 (April 26, 1996) requires that any person doing business with the Federal government furnish a Social Security Number or tax identification number. This is an amendment to title 31, Section 7701. Failure to furnish the requested information may result in OPM's inability to determine your life insurance coverage.

We think 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), Reports and Forms Manager, Paperwork Reduction Project (3206-0230), Washington, DC 20415-7900. 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.