

Any missing forms or information that requires you to come back later will delay your paycheck as they cannot be processed with everything being completed.

If possible, fill out as much online as possible so responses are legible. Some letters and numbers can be hard to decipher, please be clear. (Is it a zero or the letter "o", is it the number one or the letter "I" or "L").

Cross outs or scribbles over mistakes on the W-4 and M4 invalidate the form. If you make an error, print a new copy and start again.

If you need further information on the forms in pages 3-10, visit the [HR Forms](#) site and you can review each one individually.

Returning staff - skip the I-9 on page and if your direct deposit info hasn't changed print page 11 and write no change.

Staff under 18 - A parent must also sign your CORI form.

Here is a page-by-page list including the most often missed items, tips and exceptions.

- Page 1 - Checklist: If you can't check everything off, unless you are exempt for a few, your packet is not complete, try again!
- Page 2 - Employee Form: Only the top half is for you
- Page 3 - I-9: Fill out section 1 only. Bring your passport or a state issued license or ID AND either a Social Security Card, or a birth certificate
If you arrive without these forms of identification you will have to come back to HR **(returning staff skip to page 4)**
- Page 4 - W-2 Email Consent: Fill out, sign after printed
- Page 5 - W-4: Fill out, sign after printed
- Page 6 - M-4: Fill out, sign after printed
- Page 7 - SSA: Fill out, sign after printed, we will fill in your employee id#
- Page 8 - OBRA: Fill out
- Page 9 - OBRA: Don't forget to fill out your name and SSN at the top of the page. For the beneficiary section you need a parent's SSN and date of birth.
- Page 10 - OBRA: Don't forget to fill out your name and SSN at the top of the page. Sign after printed
- Page 11 - Direct Deposit: You must have a voided check or a direct deposit form from your bank. If you arrive without you will have to come back. **(returning staff, print and write "NO CHANGE" if nothing has changed, no need to bring another check or bank form)**
- Page 12 - Certification of Seasonal Employment: Fill out, sign after printed
- Page 13 - Policy: Visit the website, read the policies and check ALL of the boxes
- Page 14-15 - CORI: Fill out, look for required fields, sign after printed



TOWN OF HOLLISTON
NEW SEASONAL EMPLOYEE CHECKLIST

Welcome to your seasonal position with the Town of Holliston!

Please bring the following forms and documentation to the Recreation Department, 1750 Washington Street, or to the Human Resources Office on the Lower Level of Town Hall, 703 Washington Street.

Seasonal Employment Forms can be found on the Town website on the Human Resources page at <https://www.townofholliston.us/human-resources/pages/new-employee-information>

If you have any questions, or would like to review the forms with us, please call Human Resources at 508-474-3335.

REQUIRED FORMS CHECKLIST:

- ☐ New Employee Form
- ☐ I-9 Employment Eligibility Verification Form & documentation (required if new employee)
- ☐ W2 Consent for Email Delivery Form
- ☐ W4- Federal Income Tax Withholding Form
- ☐ M4- State Income Tax Withholding Form
- ☐ Social Security Acknowledgment Form
- ☐ Mandatory Massachusetts Deferred Compensation OBRA Form (in lieu of social security)
- ☐ Direct Deposit Form and Authorized Bank Account Information
- ☐ Certification of Seasonal Employment
- ☐ Policy Acknowledgment Form
- ☐ CORI (signed by parent too if under 18)
- ☐ Work Permit (required if under 18)

HUMAN RESOURCES DEPARTMENT

TOWN HALL, 703 WASHINGTON STREET, HOLLISTON, MASSACHUSETTS 01746-2168

TEL: 508-474-3335 FAX: 508-474-5923

www.townofholliston.us

NEW EMPLOYEE FORM

DATE: _____ JOB DESCRIPTION: _____

NAME: _____
PLEASE PRINT

SOCIAL SECURITY #: _____ BIRTH DATE: _____

ADDRESS: _____ GENDER: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____ MARITAL STATUS: ☐ Single ☐ Married

EMAIL ADDRESS: _____

IN CASE OF EMERGENCY NOTIFY: _____

RELATIONSHIP _____ TELEPHONE # _____
HOME, WORK, CELL, OTHER

ETHNICITY: _____ (CAUCASIAN, ASIAN, BLACK, HISPANIC, AMERICAN INDIAN)

SUPERVISOR'S SECTION

DATE OF EMPLOYMENT: _____

DEPARTMENT NAME: Parks & Recreation DEPARTMENT #: 650

SCHEDULED HOURS PER PAY PERIOD: varies

POSITION TITLE: _____ PAY TYPE _____

ACCOUNT NUMBER TO BE PAID FROM: _____

STATUS: _____ FULL TIME PERMANENT - 35 TO 40 HOURS WEEKLY
_____ TEMPORARY – WORKING LESS THAN 1 YEAR, # MONTHS _____
_____ PART TIME
☒ SEASONAL _____ ELECTED OFFICIAL
_____ FIREFIGHTER/EMT _____ LONG TERM SUB

PAY FREQUENCY: weekly GRADE _____ STEP _____
(PLEASE PROVIDE AUTHORIZATION IF EMPLOYEE HIRED AT OTHER THAN STEP 1)

SALARY: _____ HOURLY /WEEKLY RATE _____

ACCRUALS:
VACATION _____ SICK _____ PERSONAL _____

SUPERVISOR'S SIGNATURE _____

DATE _____
8/2020



Employment Eligibility Verification

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

USCIS
Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
		<input type="checkbox"/> 1. A citizen of the United States					
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
		<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any)					
If you check Item Number 4. , enter one of these:							
USCIS A-Number		OR	Form I-94 Admission Number		OR	Foreign Passport Number and Country of Issuance	
Signature of Employee					Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		First Day of Employment (mm/dd/yyyy):
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 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 		<ol style="list-style-type: none"> 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 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. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p>For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p>The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



W-2 and 1095 Consent for E-Mail Delivery

- ☐ Consent to receive Form W-2 and 1095 as via e-mail
- ☐ Change of Consent- I do not wish to receive my W-2 and 1095 via e-mail

PLEASE PRINT CLEARLY

Employee Name: _____ Last four digits of SSN: _____

Your W-2 and 195 will be sent to your Primary E-Mail Address as listed in your Employee Master record. If you have your check direct deposited, your Payroll Advice uses this same address for e-mail delivery. You can change this on the Employee Self Service website at any time.

The W-2 AND 1095 document are password protected. To open the attachment you will need to enter the last four digits of your SSN.

Note: The W-2 AND 1095 forms will be a Portable Document Format (PDF) that requires Adobe Acrobat Reader. If you do not already have it installed, you may download a copy free from the following address, <http://www.adobe.com/products/acrobat/readstep2.html>.

IMPORTANT DISCLOSURE INFORMATION

- If this form is not signed and returned to the payroll department for consent to receive a W-2 AND 1095 via e-mail, the employee will receive a paper Form W-2 AND 1095.
- The only requirement to open the PDF attachment will be a copy of Adobe Acrobat Reader. Your e-mail service provider must accept password protected attachments.
- This consent will remain in effect until the employee signs another form and checks the "Change of Consent" box that will release the Town of Holliston to return to sending the employee their Form W-2 and 1095 as a printed copy. This change of consent will only apply to future Form W-2 and 1095 forms and does not apply to the previously issued Forms W-2 and 1095.
- At any time, an employee may request an official printed Form W-2 from the Town of Holliston. That request will not change the consent to receive future Form W2 forms electronically by e-mail.
- This consent remains in effect after a person is no longer an employee of the Town of Holliston. All former employees of the Town of Holliston have the ability to update their e-mail information using the Employee Self Service (ESS) web site. All former employees remain active on the ESS website to be able to view pay history, W-2s and 1095and leave history. .

Return completed form to: Email: treasurer@holliston.k12.ma.us
Interoffice Mail: Treasurer-W2

Signature: _____ Date: _____
(By signing your name you are agreeing to the information on this form.)

Received by: _____ Date Updated in MUNIS _____

Employee's Withholding Certificate
Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.
Give Form W-4 to your employer.
Your withholding is subject to review by the IRS.

OMB No. 1545-0074

2024

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

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; or (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate <input type="checkbox"/>
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Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)

FORM
M-4

MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

Rev. 8/02



Print full name
Print home address.....

Social Security no.
City..... State..... Zip

Employee:

File this form or Form W-4 with your employer. Otherwise, Massachusetts Income Taxes will be withheld from your wages without exemptions.

Employer:

Keep this certificate with your records. If the employee is believed to have claimed excessive exemptions, the Massachusetts Department of Revenue should be so advised.

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

1. Your personal exemption. Write the figure "1." If you are age 65 or over or will be before next year, write "2"
2. If married and if exemption for spouse is allowed, write the figure "4." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "5." See Instruction C
3. Write the number of your qualified dependents. See Instruction D
4. Add the number of exemptions which you have claimed above and write the total
5. Additional withholding per pay period under agreement with employer \$
 - A. ☐ Check if you will file as head of household on your tax return.
 - B. ☐ Check if you are blind.
 - C. ☐ Check if spouse is blind and not subject to withholding.
 - D. ☐ Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed \$8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

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

Date Signed

THIS FORM MAY BE REPRODUCED

THE COMMONWEALTH OF MASSACHUSETTS, DEPARTMENT OF REVENUE

A. Number. If you claim **more** than the correct number of exemptions, civil and criminal penalties may be imposed. You may claim a smaller number of exemptions. If you do not file a certificate, your employer must withhold on the basis of no exemptions.

If you expect to owe more income tax than will be withheld, you may either claim a smaller number of exemptions or enter into an agreement with your employer to have additional amounts withheld.

You should claim the total number of exemptions to which you are entitled to prevent excessive overwithholding, unless you have a significant amount of other income.

If you work for more than one employer at the same time, you must not claim any exemptions with employers other than your principal employer.

If you are married and if your spouse is subject to withholding, each may claim a personal exemption.

B. Changes. You may file a new certificate at any time if the number of exemptions **increases**. You **must** file a new certificate within 10 days if the number of exemptions previously claimed by you **decreases**. For example, if during the year your dependent son's income indicates that you will not provide over half of his support for the year, you must file a new certificate.

C. Spouse. If your spouse is not working or if she or he is working but not claiming the personal exemption or the age 65 or over exemption, generally you may claim those exemptions in line 2. However, if you are planning to file separate annual tax returns, you should not claim withholding exemptions for your spouse or for any dependents that will not be claimed on your annual tax return.

If claiming a wife or husband, write "4" in line 2. Using "4" is the withholding system adjustment for the \$3,850 exemption for a spouse.

D. Dependent(s). You may claim an exemption in line 3 for each individual who qualifies as a dependent under the Federal Income Tax Law. In addition, if one or more of your dependents will be under age 12 at year end, add "1" to your dependents total for line 3.

You are not allowed to claim "federal withholding deductions and adjustments" under the Massachusetts withholding system.

If you have income not subject to withholding, you are urged to have additional amounts withheld to cover your tax liability on such income. See line 5.

IF YOU CLAIM THE SAME NUMBER OF EXEMPTIONS FOR MASSACHUSETTS AND U.S. INCOME TAXES, COMPLETE U.S. FORM W-4 ONLY.

Statement Concerning Your Employment in a Job Not Covered by Social Security

Employee Name _____ Employee ID# _____

Employer Name _____ Employer ID# _____

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

Windfall Elimination Provision

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2013, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$395.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to Social Security Publication, "Windfall Elimination Provision."

Government Pension Offset Provision

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security (\$500 - \$400=\$100). Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to Social Security Publication, "Government Pension Offset."

For More Information

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free 1-800-772-1213, or for the deaf or hard of hearing call the TTY number 1-800-325-0778, or contact your local Social Security office.

I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security Benefits.

Signature of Employee _____ Date _____



Participant Enrollment Governmental 457(b) Plan

Massachusetts Deferred Compensation SMART Plan - Mandatory OBRA

98966-02

Participant Information

Last Name First Name MI
(The name provided MUST match the name on file with Service Provider.)

Mailing Address

City State Zip Code

() ()
Home Phone Work Phone

☐ Check box if you prefer to receive quarterly account statements in Spanish.

Social Security Number

E-Mail Address

☐ Married ☐ Unmarried ☐ Female ☐ Male

Mo Day Year Mo Day Year

Date of Birth Date of Hire

Annual Income (Required for My Total Retirement enrollment)

Do you have a retirement savings account with a previous employer or an IRA? ☐ Yes or ☐ No

Important Notice: Employees participating in the Massachusetts Deferred Compensation SMART Plan- OBRA Mandatory Plan (the Plan) must complete Social Security Form SSA-1945. The Plan has been designated as an alternative retirement system for part time employees not covered by their employers retirement system. The SSA-1945 explains the potential effects of the Windfall Elimination Provision and Government Pension Offset Provision under the Social Security law which may reduce the amount of your Social Security retirement or disability benefits, and/or benefits received by you as a spouse or an ex-spouse. If you have any questions regarding SSA-1945 or if you have not completed SSA-1945, please contact your employer.

Payroll Information

Division Name

To be completed by
Representative: _____
Division Number

My Total Retirement Information

The My Total Retirement provided by Empower Advisory Group, LLC will automatically direct your investment elections and will rebalance your account periodically, as necessary. This election will be effective as soon as administratively feasible following receipt of your completed enrollment form and signed Advisory Services Agreement. By electing My Total Retirement, you agree to the fees associated with this service and understand the fees will be deducted from your account in accordance with the attached Advisory Services Agreement. If you prefer to make your own investment decisions and not participate in this service, simply select the Select My Own Investment Options box and enter your investment instructions in the Investment Option Information section.

My Total Retirement:

☐ By checking this box, I elect to have my account professionally managed by Empower Advisory Group, LLC until such time as I cancel my enrollment in the service.

-OR-

Select My Own Investment Options:

☐ I elect to direct my own investments.

I understand and agree that my employer and other Plan fiduciaries will not be liable for the results of my personal investment decisions.

Make your investment election for future deposits in the Investment Option Information section.

Do not complete this section if you are electing to enroll in the My Total Retirement.

Investment Option Information (applies to **all** contributions) - Please refer to your communication materials for information regarding each investment option.

I understand that funds may impose redemption fees on certain transfers, redemptions or exchanges if assets are held less than the period stated in the fund's prospectus or other disclosure documents. I will refer to the fund's prospectus and/or disclosure documents for more information.

INVESTMENT OPTION				INVESTMENT OPTION			
NAME	TICKER	CODE	%e	NAME	TICKER	CODE	
SMART Capital Preservation Fund.....	N/A	MELINC		SMARTPath 2040 Retirement Fund.	N/A	SMPT40	
SMARTPath Retirement Allocation Fund.....	N/A	SMPT00		SMARTPath 2045 Retirement Fund.	N/A	SMPT4S	
SMARTPath 2010 Retirement Fund.....	N/A	SMPT10		SMARTPath 2050 Retirement Fund.	N/A	SMPTSO	
SMARTPath 2015 Retirement Fund.....	N/A	SMPT1S		SMARTPath 2055 Retirement Fund.	N/A	SMPTSS	
SMARTPath 2020 Retirement Fund.....	N/A	SMPT20		SMARTPath 2060 Retirement Fund.	N/A	SMPT60	
SMARTPath 2025 Retirement Fund.....	N/A	SMPT2S		SMARTPath 2065 Retirement Fund.	N/A	SMPT6S	
SMARTPath 2030 Retirement Fund.....	N/A	SMPT30		MUST INDICATE WHOLE PERCENTAGES			=100%
SMARTPath 2035 Retirement Fund.....	N/A	SMPT3S					

Plan Beneficiary Designation

This designation is effective upon execution and delivery to Service Provider at the address below. I have the right to change the beneficiary. If any information is missing, additional information may be required prior to recording my beneficiary designation. If my primary and contingent beneficiaries predecease me or I fail to designate beneficiaries, amounts will be paid pursuant to the terms of the Plan Document or applicable law.

You may only designate one primary and one contingent beneficiary on this form. However, the number of primary or contingent beneficiaries you name is not limited. If you wish to designate more than one primary and/or contingent beneficiary, do not complete the section below. Instead, complete and forward the Beneficiary Designation form.

Primary Beneficiary

100.00%

% of Account Balance	Social Security Number	Primary Beneficiary Name	Date of Birth
()		Relationship (Required - If Relationship is not provided, the form will be rejected and sent back for clarification.)	
Phone Number (Optional)		<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Grandchild <input type="radio"/> Sibling <input type="radio"/> My Estate <input type="radio"/> A Trust <input type="radio"/> Other	
		<input type="radio"/> Domestic Partner	

Contingent Beneficiary

100.00%

% of Account Balance	Social Security Number	Contingent Beneficiary Name	Date of Birth
()		Relationship (Required - If Relationship is not provided, the form will be rejected and sent back for clarification.)	
Phone Number (Optional)		<input type="radio"/> Spouse <input type="radio"/> Child <input type="radio"/> Parent <input type="radio"/> Grandchild <input type="radio"/> Sibling <input type="radio"/> My Estate <input type="radio"/> A Trust <input type="radio"/> Other	
		<input type="radio"/> Domestic Partner	

Participation Agreement

Withdrawal Restrictions - I understand that the Internal Revenue Code (the "Code") and/or my employer's Plan Document may impose restrictions on transfers and/or distributions. I understand that I must contact the Plan Administrator to determine when and/or under what circumstances I am eligible to receive distributions or make transfers.

I understand if I elect to have my account managed by Empower Advisory Group, LLC, that my entire account, including any transfers or rollovers, will be professionally managed and I have not completed the Investment Option Information section. In the event investment option information is completed, my election to have my account professionally managed will override my investment option elections. Dollar cost averaging and asset allocation are not available if my account is professionally managed. I understand that the applicable fees will be deducted from my account. In order to enroll in the My Total Retirement, I understand that I must provide my date of birth, gender, marital status, state of residence and annual income. If any of this information is not provided, I understand that I will not be enrolled in the My Total Retirement.

Compliance With Plan Document and/or the Code - Participation in this Plan is mandatory. A deduction will be taken from your wages and invested on your behalf based on your employer's Plan Document. I agree that my employer or Plan Administrator may take any action that may be necessary to ensure that my participation in the Plan is in compliance with any applicable requirement of the Plan Document and/or the Code. I understand that the maximum annual limit on contributions is determined under the Plan Document and/or the Code. I understand that it is my responsibility to monitor my total annual contributions to ensure that I do not exceed the amount permitted. If I exceed the contribution limit, I assume sole liability for any tax, penalty, or costs that may be incurred.

Incomplete Forms - I understand that in the event my Participant Enrollment form is incomplete or is not received by Service Provider at the address below prior to the receipt of any deposits, I specifically consent to Service Provider retaining all monies received and allocating them to the default investment option.

Account Corrections - I understand that it is my obligation to review all confirmations and quarterly statements for discrepancies or errors. Corrections will be made only for errors which I communicate within 90 calendar days of the last calendar quarter. After this 90 days, account information shall be deemed accurate and acceptable to me. If I notify Service Provider of an error after this 90 days, the correction will only be processed from the date of notification forward and not on a retroactive basis.

My Total Retirement Fee - If you elect the My Total Retirement, a quarterly fee will be assessed. If you wish to cancel your enrollment in the future please call your Plan's Voice Response System number.

Signature(s) and Consent

Participant Consent

I have completed, understand and agree to all pages of this Participant Enrollment form including the terms of the My Total Retirement Agreement.

Deferral agreements must be entered into prior to the first day of the month that the deferral will be made.

Participant Signature

Date

A handwritten signature is required on this form. An electronic signature will not be accepted and will result in a significant delay.

After all signatures have been obtained, this form can be:

Uploaded electronically to:

OR

Sent regular mail to:

OR

Sent express mail to:

Login to account at

Empower

Empower

www.mass-smart.com

PO Box 173764

8515 E. Orchard Road

Click on *Upload Documents* to submit

Denver, CO 80217-3764

Greenwood Village, CO 80111

We will not accept hand delivered forms at express mail addresses.

Securities, when presented, are offered and/or distributed by Empower Financial Services, Inc., Member FINRA/SIPC. EFSI is an affiliate of Empower Retirement, LLC; Empower Funds, Inc.; and registered investment adviser Empower Advisory Group, LLC. This material is for informational purposes only and is not intended to provide investment, legal or tax recommendations or advice.

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

EMPLOYEE NAME (PRINT) _____

EMPLOYEE NUMBER _____

BANK NAME _____

BANK ADDRESS _____

ACCOUNT TYPE: ☐ CHECKING ☐ SAVING

ROUTING NUMBER _____

ACCOUNT NUMBER _____

PRIMARY DEPOSIT _____ SECONDARY DEPOSIT _____
(AMOUNT) (AMOUNT)

EMPLOYEE'S EMAIL ADDRESS _____

I hereby authorize the Town of Holliston to deposit my net pay, or my secondary deposit, at the financial institution named above. I understand that the Town of Holliston may cause my account to be adjusted to the extent necessary to correct any over-deposits, and I agree to hold the above named financial institution harmless for any erroneous deposits or adjustments not caused the financial institution.

It is understood that this agreement may be terminated by me at any time with written notification to the Town of Holliston. Any such notification to the Town shall be effective only with respect to entries initiated by the Town after receipt of such notification and reasonable opportunity to act on it. Any such notification to the Bank by the employee is unacceptable. The Bank may terminate this agreement by written notice to the employee for just cause.

EMPLOYEE SIGNATURE

DATE

PROVIDE EITHER A DIRECT DEPOSIT AUTHORIZATION FORM COMPLETED BY YOUR BANK OR A VOIDED CHECK WHEN YOU SUBMIT THIS FORM. CHANGES TO YOUR DIRECT DEPOSIT ACCOUNTS NEED TO BE SUBMITTED IN PERSON TO THE PAYROLL DEPARTMENT LOCATED IN THE TREASURER'S OFFICE AT THE HOLLISTON TOWN HALL.



NOTICE TO EMPLOYEES
Certification as a Seasonal Employer

Employer: Town of Holliston _____

EAN: 78-301390 _____

Plan#: 2022-83 _____

The above-named employer has been approved by the Massachusetts Department of Unemployment Assistance for certification as a seasonal employer. This applies only to the category of employees listed on the Notice of Seasonal Determination dated 2/2/22 _____

If you are a seasonal employee, seasonal wages cannot be used to establish an Unemployment Insurance benefit claim, except under certain conditions. A seasonal employee is one who is hired to work for a specific time period totaling less than 20 weeks in a calendar year. If you were hired as a seasonal employee, you must be notified in writing by your employer before beginning your seasonal employment.

Employee Signature

_____ provided me with a copy of the Seasonal Determination from the Department of Unemployment Assistance dated _____. I understand that I am a seasonal employee and that wages from this occupation cannot be used to establish an Unemployment Insurance benefit claim, except under certain conditions.

Employee Name (Print): _____

Employee Signature: _____ Date: _____

Employer Signature

I have provided the above-referenced employee with a copy of the Seasonal Determination from the Department of Unemployment Assistance dated 2/2/22 _____. The employee understands that he/she is a seasonal employee and that wages from this occupation cannot be used to establish an Unemployment Insurance benefit claim, except under certain conditions.

Name of Employer Representative (Print): Kathleen Buckley _____

Employer Rep. Signature: Kathleen Buckley _____ Date: 3/14/22

Seasonal Certification Unit
Email: EmployerCharge@detma.org
Phone: (617) 626-5075



NOTICE TO EMPLOYEES
Certification as a Seasonal Employer

Employer: Town of Holliston _____

EAN: 78-301390 _____

Plan#: 2022-83 _____

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Employee Signature

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Employee Name (Print): _____

Employee Signature: _____ Date: _____

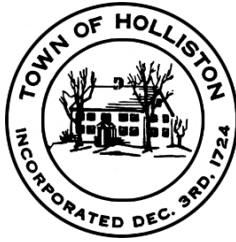
Employer Signature

I have provided the above-referenced employee with a copy of the Seasonal Determination from the Department of Unemployment Assistance dated 2/2/22 _____. The employee understands that he/she is a seasonal employee and that wages from this occupation cannot be used to establish an Unemployment Insurance benefit claim, except under certain conditions.

Name of Employer Representative (Print): Kathleen Buckley _____

Employer Rep. Signature: Kathleen Buckley _____ Date: 3/14/22

Seasonal Certification Unit
Email: EmployerCharge@detma.org
Phone: (617) 626-5075



TOWN OF HOLLISTON

POLICY ACKNOWLEDGMENT FORM SEASONAL EMPLOYEES

Information regarding the following acknowledgments can be found on the Town of Holliston's website at <https://www.townofholliston.us/human-resources/pages/employee-policies>

IT IS YOUR RESPONSIBILITY TO READ, DOWNLOAD AND/OR PRINT THE FOLLOWING FOR YOUR RECORDS.

I acknowledge the receipt of the following policies:

- ☐ Direct Deposit Policy
- ☐ Drug and Alcohol Policy
- ☐ NON-DISCRIMINATION STATEMENT PREGNANCY AND PREGNANCY-RELATED CONDITIONS
- ☐ Sexual Harassment Policy
- ☐ Conflict of Interest Law



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services 200
Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS



This form is not to be faxed. Please return form to organization.

**Criminal Offender Record Information (CORI)
Acknowledgement Form**

To be used by organizations using consumer reporting agencies to conduct CORI checks for employment, volunteer, subcontractor, licensing, and housing purposes.

Town of Holliston
(Organization) is registered under the provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing. _____
Town of Holliston
(Organization) has authorized _____
Town of Holliston
(Consumer Reporting Agency) to submit CORI checks to the Massachusetts Department of Criminal Justice Information Services (DCJIS) on its behalf.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to _____
Town of Holliston
(Consumer Reporting Agency) to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing _____
Town of Holliston
(Organization) with written notice of my intent to withdraw consent to a CORI check. I also understand that this form is a CORI acknowledgement form and I am entitled to additional consumer reporting disclosure forms under the Fair Credit Reporting Act. If I have not received those disclosures, I should contact _____
Town of Holliston
(Organization) to request this information.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

I also understand that the _____
Town of Holliston
(Consumer Reporting Agency) _____
Town of Holliston
(Organization) may conduct subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature of CORI Subject

Date

Signature of Parent if Subject is under 18

Date



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS



SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: _____ -- _____ ☐ No Social Security Number

Sex: _____ Height: _____ ft. _____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

Verified by:

Print Name of Verifying Employee

Signature of Verifying Employee

Date