TheStandard®

Standard Insurance Company
Claims Administrator 800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208-2800

County of Orange California Disability Salary Continuance Claim Packet Instructions

Dear Disability Salary Continuance Claimant:

The following Disability Salary Continuance information is for your review and action. We understand that being disabled does not cease your financial obligations and we hope that the Disability Salary Continuance benefits assist you during the time that you are unable to work and are off payroll. If you are unable to return to work at the end of your Disability Salary Continuance period, you may be eligible for Long Term Disability (LTD) benefits through Standard Insurance Company (The Standard).

This packet contains forms to apply for your Disability Salary Continuance benefits and the Plan Document that provides specific information about the plan. It is also intended to address common questions about Disability Salary Continuance claims and procedures. We recommend that you save this material for your future reference.

How To Apply for Disability Salary Continuance Benefits

A Disability Salary Continuance application includes three forms that must be completed, 1) the claim form, 2) an Authorization to Obtain Information form and 3) IRS form W-4.

1. Complete the section of the claim form called "To be Completed by Employee".
2. Have your physician complete the section on the claim form called "Attending Physician's Statement".
3. Complete the section of the claim form called "Authorization to Obtain Information".
4. Complete the IRS form W-4.
5. Send all completed forms to:

   County of Orange/Employee Benefits
   333 W. Santa Ana Blvd., Suite 137
   Santa Ana, CA 92701

Important Notice: Incomplete forms will cause a delay in processing your disability claim form.

Once all completed forms are received, Employee Benefits will:

1. Request written verification from your agency that all of your accrued sick time/annual leave that is required has been exhausted. *(For your information, subsequent payment of vacation or comp time will not affect your Disability Salary Continuance payments. Subsequent payment of Catastrophic Leave will affect your Disability Salary Continuance payments. Please contact the Employee Benefits Office as soon as you are awarded Catastrophic Leave.)*
2. The Employee Benefits Office will complete the "To Be Completed by Employer" section of the claim form.
3. Send all completed forms to The Standard.

Once The Standard receives your completed claim form, it will take approximately one week to make a claim decision. If a decision has not been reached within one week, you will be notified with the details. Once a decision (approval or denial) has been made on your claim, you will also be notified. The Standard will consider the applicable elimination period and issue payments each Wednesday as long as you are eligible for benefits.

Pregnancy Related Disabilities

Soon after your baby is born, you must:

1. Notify The Standard at (800) 368-2859 to report the actual date and type of delivery.
2. It is your responsibility to report your life event to the County of Orange Benefits Center within 30 days from the date of birth to add the baby to your health plan. You can add your baby by logging on to the Benefits Center Web Site at www.benefitsweb.com/countyoforange.html or call the Benefits Resource Line at the toll free number (866) 325-2345 and follow the instructions to speak with a Benefits Specialist.

Other Benefits That May Reduce Your Disability Benefits

Other benefits you receive may reduce the amount of Disability Salary Continuance benefits due you. The Disability Salary Continuance Plan Document and Long Term Disability group insurance certificates list these benefits, which may include, but are not limited to, sick leave, Workers' Compensation, Catastrophic Leave and Retirement.

Note: Any overpayments of Disability Salary Continuance benefits must be repaid in full.

Extension of Disability

In most cases, The Standard will cease benefit payments on the anticipated return to work date your physician indicates on your claim form. If your disability extends past this date, you must:

1. Notify your immediate supervisor.
2. Have your physician complete a new Attending Physician's Statement. An Attending Physician's Statement (APS) or the other medical questionnaire will be included with the correspondence you receive from The Standard. If you need an additional APS or medical questionnaire, you may request them directly from The Standard at their toll free number (800) 368-2859.
3. Once completed, send the new Attending Physician's Statement to The Standard.

To avoid a lapse in eligible benefit payments, the above steps should take place as soon as you are aware that additional time off work is required due to your disability.

Federal Income Tax Withholding

The Internal Revenue Service requires that Federal Income Tax be withheld from your Disability Salary Continuance Benefits. Therefore, you must complete an IRS Form W-4 and submit it with your disability claim. If you have questions on how you should complete the form, you should contact your tax advisor.

Medicare Tax Withholding

If you were hired by the County of Orange on or after April 1, 1986, the Medicare Tax will be withheld from your Disability Salary Continuance benefits.

Return to Work

If you return to work prior to the anticipated return to work date your physician indicates on your claim form, immediately notify The Standard. This will prevent overpayments of benefits. Any overpayments of Disability Salary Continuance benefits must be repaid in full.

Need Additional Information

We hope that this information addresses any questions you may have had regarding your Disability Salary Continuance plan. If not:

- You should contact The Standard at their toll free number (800) 368-2859 for general plan questions and/or specific details about your Disability Salary Continuance claim or determination.

Reset

Standard Insurance Company

Claims Administrator 800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208-2800

County of Orange California Disability Salary Continuance Employer/Employee's Statement

Submit Completed Form to: County of Orange/Employee Benefits, 333 W. Santa Ana Blvd., Suite 137, Santa Ana, CA 92701

TO BE COMPLETED BY EMPLOYEE

Full Name:	Social Security Number:	Phone No.: ( )	Birthdate:	Sex: ☐ M ☐ F
Mailing Address:		City:	State:	Zip Code:

1. Is your disability work related? ☐ Yes ☐ No

2. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No
   If no, do you intend to file? ☐ Yes ☐ No

3. Last active day at work:

4. Date you became unable to work at your occupation because of disability:

5. Date you returned or expect to return to work:

6. Is your disability due to:
   ☐ Accident. When and where did it happen?
   ☐ Illness. When did you first notice and what is the nature of your disability?

7. How does your disability prevent you from working?

8. Have you had a previous disability claim with The Standard? ☐ Yes ☐ No

9. Pregnancy: Expected delivery date: _____
   Actual delivery date: _____
   Type of delivery: ☐ Vaginal ☐ C-section

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 4 of this form.

By signing this statement, you also agree to pay the County of Orange back any Disability Salary Continuance benefits that were paid to you for any period of time for which you also received income or benefits from other sources.

Signature: _____ Date: _____

Have or will you be applying for:
Disability Retirement ☐ Yes ☐ No
Catastrophic Leave ☐ Yes ☐ No

Note to Employee: Complete top portion of Attending Physician's Statement on page 5.

TO BE COMPLETED BY EMPLOYER

Employee's Full Name:	Social Security Number:	Job Title:	1. Date Employed:

2. Is employee insured for Short Term Disability? ☐ Yes ☐ No
   Effective date: _____
   Is employee insured for Long Term Disability? ☐ Yes ☐ No
   Effective date: _____
   Is employee insured for Group Life Insurance through The Standard? ☐ Yes ☐ No

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for:
   Workers' Compensation ☐ Yes ☐ No Other: _____

5. Employee's weekly earnings: $ _____

6. Last active day at work: _____

7. Job status when disability began: ☐ Full-time (____ hours/week)
   Rep Unit: _____ Agency: _____

8. Date employee returned to work: _____

9. Last day through which sick leave benefits were paid: _____

10. Last day through which any compensation was paid by employer: _____ Type: _____

11. Is employee subject to: Social Security taxes? ☐ Yes ☐ No Medicare taxes? ☐ Yes ☐ No

12. Does the employee pay all or a portion of the premium for: STD coverage? ☐ Yes ☒ No LTD coverage? ☐ Yes ☒ No

Employer:	Plan No.:	Phone No.:
The County of Orange	**639024**	**(714) 834-6282**

Mailing Address:	City:	State:	Zip Code:
333 W. Santa Ana Blvd., Suite 137	**Santa Ana**	**CA**	**92701**

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 4 of this form.

Signature: _____ Date: _____ Prepared By: _____

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Standard Insurance Company

Claims Administrator 800.368.2859 Tel 800.378.6053 Fax
PO Box 2800 Portland OR 97208-2800

County of Orange California Disability Salary Continuance Attending Physician's Statement

TO BE COMPLETED BY EMPLOYEE

Full Name:	Employer: **The County of Orange**	Plan No: **639024**

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

The following information is needed to document your patient's inability to work. The patient is responsible for completing this form without expense to the plan sponsor or The Standard.

1. Diagnosis

A. Diagnosis: | ICDA Classification:

B. Symptoms: | C. Objective Findings:

Height: _____ Weight: _____ B/P: _____ /_____

2. Pregnancy *(if applicable)*

A. Expected date of delivery: | B. Actual date of delivery: | C. Type of delivery: ☐ Vaginal ☐ C-section

D. Significant complications, if any:

3. History

A. Date you recommended the patient stop work: | **B. When did symptoms appear or accident happen?**

C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No | If yes, when? _____

D. Is this condition related to the patient's employment? ☐ Yes ☐ No | E. Did you complete a Workers' Compensation claim form? ☐ Yes ☐ No

4. Treatment

A. Date of first visit: | B. Date(s) of subsequent visits: | C. Date of most recent visit:

D. Planned course and duration of treatment *(include surgery and medications, if any)*:

5. Level of Functional Impairment

A. Describe the patient's physical, mental and cognitive limitations, if any.

B. In a work day given two breaks and a meal break, your patient can:

Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total Hours									With positional change
Sit	8☐	7☐	6☐	5☐	4☐	3☐	2☐	1☐	*(hrs)*	_____
Stand	8☐	7☐	6☐	5☐	4☐	3☐	2☐	1☐	*(hrs)*	_____
Walk	8☐	7☐	6☐	5☐	4☐	3☐	2☐	1☐	*(hrs)*	_____
Alternately sit/stand	8☐	7☐	6☐	5☐	4☐	3☐	2☐	1☐	*(hrs)*	_____

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

C. Is the patient competent to manage insurance benefits? ☐ Yes ☐ No
If no, is the patient competent to appoint someone to help manage the insurance benefits? ☐ Yes ☐ No

6. Hospitalization *(if applicable)*

A. Date admitted: Date discharged: | B. Reason:

C. Name and location of hospital (city/state):

7. Prognosis

A. Since onset of symptoms, the patient's condition has: ☐ Improved ☐ Not changed ☐ Retrogressed

B. When do you anticipate the patient can return to work? ☐ **Date:** _____ ☐ **Unable to determine, follow up in** _____ **weeks** ☐ **Never**

8. Physician Information *(Please type or print)*

Name of physician completing this form: | Phone Number: ( )

Specialty: | Tax ID#: | Fax Number: ( )

Mailing Address: | City: | State: | Zip Code:

Acknowledgement
I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on page 6 of this form.

Signature: _____ Date: _____

Some states require us to provide the following information to you:

CALIFORNIA RESIDENTS

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO RESIDENTS

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DISTRICT OF COLUMBIA RESIDENTS

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA RESIDENTS

Any person who knowingly and with intent to injure, defraud or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

MARYLAND AND RHODE ISLAND RESIDENTS

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY RESIDENTS

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALL OTHER RESIDENTS

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Authorization to Obtain and Release Information

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Kaiser Permanente.
- Any insurance company or annuity company.
- Any employer, policyholder or plan sponsor.
- Any organization or entity administering a benefit or leave program (including statutory benefits) or an annuity program.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency (*for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, Workers' Compensation Board, etc.*).

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

TO STANDARD INSURANCE COMPANY (Standard Insurance Company includes THE STANDARD BENEFIT ADMINISTRATORS) for my claim(s) under my Employer's self-funded Disability Plan(s) AND TO STANDARD INSURANCE COMPANY (Standard Insurance Company includes THE STANDARD BENEFIT ADMINISTRATORS), THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK, AND THEIR AUTHORIZED REPRESENTATIVES, as applicable to my insured Disability (including state statutory benefit) claim(s) (all hereinafter referred to as "The Companies", individually and collectively), AND MY EMPLOYER'S ABSENCE MANAGEMENT PROGRAM ADMINISTRATOR ("Absence Manager").

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclose my entire medical record without restriction.
- I understand that each of The Companies and Absence Manager will gather my information only if they are administering, recommending or deciding my disability or leave of absence claim(s), and will use the information to evaluate my eligibility or entitlement for benefits or leave of absence.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to The Companies and Absence Manager, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair The Companies and Absence Manager's ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits or leave of absence.
- I understand that in the course of conducting its business The Companies and Absence Manager may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, or any person performing business or legal services for them in connection with my claim(s). I understand that The Companies and Absence Manager will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing claim evaluation or administration of my employer's self-funded (and not insured) disability plans.
- I understand that The Companies and Absence Manager comply with applicable state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to redisclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by The Companies and Absence Manager may not be protected under the Health Insurance Portability and Accountability Act (HIPAA).
- I understand and agree that this authorization as used to gather information shall remain in force, as applicable to me, from the date signed below:
  - For Standard Insurance Company, the duration of my claim(s) or 24 months, whichever occurs first.
  - For The Standard Life Insurance Company of New York, the duration of my claim(s) or 24 months, whichever occurs first.
  - For Absence Manager, 24 months.
- I understand and agree that The Companies and Absence Manager may share information with each other regarding my disability and leave of absence claim(s). This authorization to share information shall remain valid for 12 months from the date signed below.
- I acknowledge that I have read this authorization and the New Mexico notice on page 8. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g., Attorney in Fact, guardian or conservator), please attach documentation of legal status.

Standard Insurance Company is a licensed insurance company in all states except New York. The Standard Life Insurance Company of New York is an insurance company licensed only in New York. An absence manager may be hired by your employer and may be one of The Companies.

FOR RESIDENTS OF NEW MEXICO

The state of New Mexico requires Standard Insurance Company to provide you with the following information pursuant to its Domestic Abuse Insurance Protection Act.

The Authorization form allows Standard Insurance Company to obtain personal information as it determines your eligibility for insurance benefits. The information obtained from you and from other sources may include confidential abuse information. "Confidential abuse information" means information about acts of domestic abuse or abuse status, the work or home address or telephone number of a victim of domestic abuse or the status of an applicant or insured as a family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close personal, family or abuse-related counseling relationship. With respect to confidential abuse information, you may revoke this authorization in writing, effective ten days after receipt by Standard Insurance Company, understanding that doing so may result in a claim being denied or may adversely affect a pending insurance action.

Standard Insurance Company is prohibited by law from using abuse status as a basis for denying, refusing to issue, renew or reissue or canceling or otherwise terminating a policy, restricting or excluding coverage or benefits of a policy or charging a higher premium for a policy.

Upon written request you have the right to review your confidential abuse information obtained by Standard Insurance Company. Within 30 business days of receiving the request, Standard Insurance Company will mail you a copy of the information pertaining to you. After you have reviewed the information, you may request that we correct, amend or delete any confidential abuse information which you believe is incorrect. Standard Insurance Company will carefully review your request and make changes when justified. If you would like more information about this right or our information practices, a full notice can be obtained by writing to us.

If you wish to be a protected person (a victim of domestic abuse who has notified Standard Insurance Company that you are or have been a victim of domestic abuse) and participate in Standard Insurance Company's location information confidentiality program, your request should be sent to Standard Insurance Company.

Form W-4 (2014)

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 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

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

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

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

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

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

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

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

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 $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** _____
(**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

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 $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children.
- If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child . . . **G** _____

H Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ► **H** _____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 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.

---------- **Separate 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
2014

1 Your first name and middle initial	Last name	**2 Your social security number**
Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	**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 2014, 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**	

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form **W-4** (2014)

Deductions and Adjustments Worksheet

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

1	Enter an estimate of your 2014 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% (7.5% if either you or your spouse was born before January 2, 1950) of your income, and miscellaneous deductions. For 2014, you may have to reduce your itemized deductions if your income is over $305,050 and you are married filing jointly or are a qualifying widow(er); $279,650 if you are head of household; $254,200 if you are single and not head of household or a qualifying widow(er); or $152,525 if you are married filing separately. See Pub. 505 for details	1	$
2	Enter: { $12,400 if married filing jointly or qualifying widow(er); $9,100 if head of household; $6,200 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 2014 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2014 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2014 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 $3,950 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

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

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

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

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

4	Enter the number from line 2 of this worksheet	4			
5	Enter the number from line 1 of this worksheet	5			
6	**Subtract** line 5 from line 4			6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here			7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed			8	$
9	Divide line 8 by the number of pay periods remaining in 2014. For example, divide by 25 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2014. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck			9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $6,000	0	$0 - $6,000	0
6,001 - 13,000	1	6,001 - 16,000	1
13,001 - 24,000	2	16,001 - 25,000	2
24,001 - 26,000	3	25,001 - 34,000	3
26,001 - 33,000	4	34,001 - 43,000	4
33,001 - 43,000	5	43,001 - 70,000	5
43,001 - 49,000	6	70,001 - 85,000	6
49,001 - 60,000	7	85,001 - 110,000	7
60,001 - 75,000	8	110,001 - 125,000	8
75,001 - 80,000	9	125,001 - 140,000	9
80,001 - 100,000	10	140,001 and over	10
100,001 - 115,000	11		
115,001 - 130,000	12		
130,001 - 140,000	13		
140,001 - 150,000	14		
150,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $74,000	$590	$0 - $37,000	$590
74,001 - 130,000	990	37,001 - 80,000	990
130,001 - 200,000	1,110	80,001 - 175,000	1,110
200,001 - 355,000	1,300	175,001 - 385,000	1,300
355,001 - 400,000	1,380	385,001 and over	1,560
400,001 and over	1,560		

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Print