How to Complete New Hire Packet

Human Resources Office
971-355-3325

REQUIRED FOR ALL EMPLOYEES

Fill out the Red box

Form **W-4**

Department of the Treasury
Internal Revenue Service

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

City or town, state, and ZIP code

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.

(c) ☐ **Single or Married filing separately**
☐ **Married filing jointly or Qualifying surviving spouse**
☐ **Head of household** (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)

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 . . . . . ☐

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)** $

Sign & date

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)

For Privacy Act and Paperwork Reduction Act Notice, see page 3. Cat. No. 10220Q Form **W-4** (2024)

W-4 2024

REQUIRED FOR ALL EMPLOYEES

Standard Form 1199A (EG)
(Rev. August 2012)
Prescribed by Treasury Department
Treasury Dept. Cir. 1075

OMB No. 1510-0007

DIRECT DEPOSIT SIGN-UP FORM

DIRECTIONS

- To sign up for Direct Deposit, the payee is to read the back of this form and fill in the information requested in Sections 1 and 2. Then take or mail this form to the financial institution. The financial institution will verify the information in Sections 1 and 2, and will complete Section 3. The completed form will be returned to the Government agency identified below.
- A separate form must be completed for each type of payment to be sent by Direct Deposit.
- The claim number and type of payment are printed on Government checks. (See the sample check on the back of this form.) This information is also stated on beneficiary/annuitant award letters and other documents from the Government agency.
- Payees must keep the Government agency informed of any address changes in order to receive important information about benefits and to remain qualified for payments.

SECTION 1 *(TO BE COMPLETED BY PAYEE)*

A NAME OF PAYEE *(last, first, middle initial)*

ADDRESS *(street, route, P.O. Box, APO/FPO)*

CITY | STATE | ZIP CODE

TELEPHONE NUMBER
AREA CODE

B NAME OF PERSON(S) ENTITLED TO PAYMENT

C CLAIM OR PAYROLL ID NUMBER
Prefix | Suffix

D TYPE OF DEPOSITOR ACCOUNT ☐ CHECKING ☐ SAVINGS

E DEPOSITOR ACCOUNT NUMBER

F TYPE OF PAYMENT *(Check only one)*
- ☐ Social Security
- ☐ Supplemental Security Income
- ☐ Railroad Retirement
- ☐ Civil Service Retirement (OPM)
- ☐ VA Compensation or Pension
- ☒ Fed. Salary/Mil. Civilian Pay
- ☐ Mil. Active
- ☐ Mil. Retire.
- ☐ Mil. Survivor
- ☐ Other _____ *(specify)*

G THIS BOX FOR ALLOTMENT OF PAYMENT ONLY *(if applicable)*
TYPE | AMOUNT

PAYEE/JOINT PAYEE CERTIFICATION

I certify that I am entitled to the payment identified above, and that I have read and understood the back of this form. In signing this form, I authorize my payment to be sent to the financial institution named below to be deposited to the designated account.

SIGNATURE	DATE
SIGNATURE	DATE

JOINT ACCOUNT HOLDERS' CERTIFICATION *(optional)*

I certify that I have read and understood the back of this form, including the SPECIAL NOTICE TO JOINT ACCOUNT HOLDERS.

SIGNATURE	DATE
SIGNATURE	DATE

SECTION 2 *(TO BE COMPLETED BY PAYEE OR FINANCIAL INSTITUTION)*

GOVERNMENT AGENCY NAME	GOVERNMENT AGENCY ADDRESS

SECTION 3 *(TO BE COMPLETED BY FINANCIAL INSTITUTION)*

NAME AND ADDRESS OF FINANCIAL INSTITUTION

ROUTING NUMBER | CHECK DIGIT

DEPOSITOR ACCOUNT TITLE

FINANCIAL INSTITUTION CERTIFICATION

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210.

PRINT OR TYPE REPRESENTATIVE'S NAME	SIGNATURE OF REPRESENTATIVE	TELEPHONE NUMBER	DATE

Financial institutions should refer to the GREEN BOOK for further instructions.
THE FINANCIAL INSTITUTION SHOULD MAIL THE COMPLETED FORM TO THE GOVERNMENT AGENCY IDENTIFIED ABOVE.

NSN 7540-01-058-0224 | **PAYEE COPY** | 1199-207

Designed using Perform Pro, WHS/DIOR, Mar 97

Fill out the Red box. In box C, input SSN

Sign & date

Select type of account, fill in account #, select Federal Salary in the Green box

*Oregon Military Department

*1776 Militia Way SE Salem, OR 97301

Provide bank name, routing # & Account Title (Checking or Savings) in the Blue box

SF1199A

REQUIRED FOR ALL EMPLOYEES

Fill out the Red box

Sign & date

Select one of the options in the Green box

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.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. 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)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)			☐ Check here if you used an alternative procedure authorized by DHS to examine documents.		

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.	First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

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.

I9 FORM

REQUIRED FOR ALL EMPLOYEES

Fill out info in Red box

APPOINTMENT AFFIDAVITS

_____ (Position to which Appointed)

_____ (Date Appointed)

_____ (Department or Agency)

_____ (Bureau or Division)

_____ (Place of Employment)

I, _____, do solemnly swear (or affirm) that--

Department: **DoD**
Bureau: **NGB**
Place of Employment: **ORNG**

A. OATH OF OFFICE

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.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO THE PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____ (Signature of Appointee)

Signature

Subscribed and sworn (or affirmed) before me this____ day of _____, 2____

at _____ (City) _____ (State)

_____ (Signature of Officer)

(SEAL)

Commission expires_____
(If by a Notary Public, the date of his/her Commission should be shown)

_____ (Title)

Note - If the appointee objects to the form of the oath on religious grounds, certain modifications may be permitted pursuant to the Religious Freedom Restoration Act. Please contact your agency's legal counsel for advice.

U.S. Office of Personnel Management
The Guide to Processing Personnel Actions

NSN 7540-00-634-4015

Standard Form 61
Revised August 2002
Previous editions not usable

SF 61

REQUIRED FOR ALL EMPLOYEES

Fill in info

Answer questions # 4 & 6. #8 is below

List dates you were in LWOP in the Green box

Answer question 8, Veterans' Preference

Sign & date

Standard Form 144 (Rev. 10/95) Page 2
Office of Personnel Management
The Guide to Processing Personnel Actions

STATEMENT OF PRIOR FEDERAL SERVICE
To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)

4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?
☐ Yes — If "Yes", check this block and skip to Item 8. ☐ No — If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?
☐ Yes — If "Yes", list the following information. ☐ No — If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	

8. Do you claim any type of veterans' preference which has not been verified?
☐ No ☐ Yes — Check one of the statements, if it applies to you. I claim preference as the:
☐ Spouse of a disabled veteran ☐ Mother of a deceased or disabled veteran ☐ Unmarried widow/widower of a veteran

9. CERTIFICATION: The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature | Date

NSN 7540-00-634-4101 Previous Edition Usable 144-114
*U.S. Government Printing Office: 1996 - 404-761/32401

List dates you were employed with *any* Federal agency in the Red box

List dates you were <u>ACTIVE</u> in *any* branch of the U.S. Armed Forces in the Blue box

SF144

REQUIRED FOR ALL EMPLOYEES

Fill in the info & answer the questions in the Red box

List branch, dates, & type of discharge for *all* ACTIVE duty in the Green box

Training is not included

Be sure to answer all Q's in the Blue boxes

Declaration for Federal Employment*

Form Approved: OMB No. 3206-0182

(This form may also be used to assess fitness for federal contract employment)

GENERAL INFORMATION

1. **FULL NAME** (Provide your full name. If you have only initials in your name, provide them and indicate "Initial only". If you do not have a middle name, indicate "No Middle Name". If you are a "Jr.," "Sr.," etc. enter this under Suffix. First, Middle, Last, Suffix)

2. **SOCIAL SECURITY NUMBER**

3a. **PLACE OF BIRTH** (Include city and state or country)

3b. **ARE YOU A U.S. CITIZEN?**

☐ YES ☐ NO (If "NO", provide country of citizenship)

4. **DATE OF BIRTH** (MM / DD / YYYY)

5. **OTHER NAMES EVER USED** (For example, maiden name, nickname, etc)

6. **PHONE NUMBERS** (Include area codes)

Day

Night

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO (If "NO", proceed to 8.)

7b. Have you registered with the Selective Service System? ☐ YES (If "YES", proceed to 8.) ☐ NO (If "NO", proceed to 7c.)

7c. If "NO," describe your reason(s) in item 16.

Military Service

8. Have you ever served in the United States military? ☐ YES (If "YES", provide information below) ☐ NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.
If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9, 10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law .

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

10. Have you been convicted by a military court-martial in the past 7 years? *(If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.* ☐ YES ☐ NO

11. Are you currently under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.* ☐ YES ☐ NO

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* ☐ YES ☐ NO

U.S. Office of Personnel Management

5 U.S.C. 1302, 3301, 3304, 3328 & 8716

Optional Form 306
Revised October 2011
Previous editions obsolete and unusable

OF 306

REQUIRED FOR ALL EMPLOYEES

Provide info requested in the Red box

Sign & date

Prior Federal employees, answer the questions in the Green box

Declaration for Federal Employment*

Form Approved: OMB No. 3206-0182

(*This form may also be used to assess fitness for federal contract employment)

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law,mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name,relationship, and the department, agency, or branch of the Armed Forces for which your relative works.* ☐ YES ☐ NO

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? ☐ YES ☐ NO

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed *(these questions are specific to your position and your agency is authorized to ask them).*

Certifications / Additional Questions

APPLICANT: If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith . **I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

17a. Applicant's Signature: _____ (Sign in ink) Date _____

17b. Appointee's Signature: _____ (Sign in ink) Date _____

Appointing Officer: Enter Date of Appointment or Conversion MM / DD / YYYY

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

18a. When did you leave your last Federal job? DATE: MM / DD / YYYY

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? ☐ YES ☐ NO ☐ DO NOT KNOW

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. ☐ YES ☐ NO ☐ DO NOT KNOW

U.S. Office of Personnel Management

5 U.S.C. 1302, 3301, 3304, 3328 & 8716

Revised October 2011

Previous editions obsolete and unusable

OF 306 (PAGE 2)

REQUIRED FOR ALL EMPLOYEES

Fill in your name in the Red box

STANDARDS OF CONDUCT

Name: Organization: Oregon Military Department

Each employee must sign a statement upon appointment in the National Guard Federal Employee Program that they have been briefed and understand the provisions of Chapter 17 of the National Guard Technician Handbook, Standards of Conduct. After reading reference information, the following statement must be signed and dated. Your signature indicates that you have initially been made aware of the standards of conduct requirements for the National Guard Federal Employee Program. If you have any questions concerning the Standards of Conduct, your supervisor will be able to help you. This statement will be filed in your Official Personnel Folder.

STATEMENT

I certify that I have been briefed and understand the standards set forth in Chapter 17 of the National Guard Technician Handbook for the National Guard Federal Employee Program.

Employee Signature

Date

Signature of Personnel Office Representative

HRO Form 905, 17 December 2019, Previous editions are obsolete

Sign & date

HRO FORM 905

REQUIRED FOR ALL EMPLOYEES

ELIGIBILITY FOR FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) OR TRICARE RESERVE SELECT (TRS) INSURANCE

To further the goal of providing affordable health insurance to Federal employees, the United States Office of Personnel Management (OPM) has issued a final rule modifying coverage under the Federal Employees Health Benefits (FEHB) Program to include certain temporary, seasonal, and intermittent employees who are identified as full-time (130 hours in a calendar month) employees. This regulation makes FEHB coverage available to these newly eligible employees no later than January 2015.

Temporary employees must have an appointment of more than 90 days in order to be eligible to enroll at the beginning of their appointment. Those temporary employees with a Not-to-Exceed (NTE) date of less than 90 days will be considered to be in a 90 day waiting period. If the expectation changes and the employee is extended past 90 days, the employee will be notified and given the opportunity to enroll promptly and no later than the 91st day of employment.

When an employee becomes eligible for FEHB, they become ineligible for TRS. Those who are currently enrolled in TRS when they become an eligible employee under FEHB, must immediately update TRS and terminate that coverage after being enrolled in FEHB. TRS runs a quarterly audit and will be notified of your eligibility date under FEHB. If coverage under TRS is not terminated accordingly, TRS can backdate a termination and the employee will have to repay TRS for all monies paid on claims retroactive to their FEHB eligibility date and may face fine and/or a charge of fraud.

A signed copy of this document will be filed in your electronic official personnel file (eOPF).

- -

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE CONDITIONS OF ELIGIBILITY FOR FEHB AND TRS INSURANCE AND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE TRS CORPORATION TO CANCEL IF NECESSARY.

Signature: Date:

Name (print): Last 4 SSN:

Date of hire:

Contact Info:
(TRS) - UnitedHealthcare Military & Veterans Customer Service (for Beneficiaries & Providers)
1-877-988-WEST (1-877-988-9378)
www.uhcmilitarywest.com

Fill out the Red box

Sign & date

ELIGIBILITY FOR FEHB/TRS

REQUIRED FOR TEMPORARY EMPLOYEES

Initial after each line in the Red box

Sign & date

CONDITIONS OF TEMPORARY EMPLOYMENT

You have accepted a temporary appointment in the Oregon National Guard technician program. Here are a few facts about your temporary employment that you need to know:

1. If you have applied for or are receiving unemployment compensation payments, it is your responsibility, under penalty of law, to notify the appropriate local office of your employment. Failure to do so can result in a penalty such as a fine, imprisonment, or both. Initial____

2. Your position is temporary and as such is limited to a definite length of time. If there is a lack of work or lack of funds, your employment may be terminated at any time. Initial____

3. Dual-Status military technicians are required to wear the uniform appropriate for the member's grade and component of the armed services while performing duties. The uniform will be worn in compliance with the regulations issued by the applicable military component. Initial____

4. During your employment, you will be earning four (4) hours of sick leave per pay period and annual leave at a rate based on your years of Federal Service including creditable active duty time. Such leave may not be used until you have reached 90 days of employment. Initial____

5. As a temporary employee, if your initial appointment is more than 90 days, you will be eligible to enroll in the Federal Employees Health Benefits (FEHB) Program immediately. If your initial appointment is less than 90 days, you will be considered to be in a 90 day waiting period before you will be eligible to enroll. If the expectation changes and your appointment is extended, you will be notified and information on your FEHB eligibility will be provided to you. Becoming eligible for FEHB will make you ineligible to continue or enroll in Tricare Reserve Select (TRS). Initial____

6. As a temporary employee you are ineligible for Federal Employees Group Life Insurance (FEGLI) or Federal Retirement coverage. Initial____

7. As a Dual-Status technician you are eligible to enroll in NGAUS Term Life and Disability Insurance. Complete open enrollment for within 31 days of your hire date OR request a application from HRO if it is passed 31 days from the date of your hire. Initial____

8. Temporary technicians may apply and be considered for indefinite and permanent appointment. Initial____

9. The appointment SF50, Notification of Personnel Action, contains your notification of separation. Do not work beyond that "not-to-exceed" without prior authorization from the Directorate for Human Resources. Initial____

I CERTIFY I HAVE READ AND UNDERSTAND THESE CONDITIONS OF TEMPORARY EMPLOYMENT

_____ _____
SIGNATURE DATE

_____
PRINT FULL NAME

CNG FORM 690-3

Fill out the Red box

OPTIONAL

SELF-IDENTIFICATION OF DISABILITY

(Please read the Privacy Act information and additional instructions on Page 2)

Name (Last, First, Middle Initial)	Date of Birth (MM/YYYY)	Social Security Number

Purpose:

Each agency in the Executive Branch of the Federal government has established programs to facilitate the hiring, placement, and advancement of individuals with disabilities. Self-identification of disability status is essential for effective data collection and analysis of the Federal government's efforts. While self-identification is voluntary, your cooperation in providing accurate information is critical to these efforts. Every precaution is taken to ensure that the information provided by each employee is kept in the strictest confidence.

ENTER CODE HERE → ☐☐

Targeted Disabilities or Serious Health Conditions:

02- Developmental Disability, for example, autism spectrum disorder
03- Traumatic Brain Injury
19- Deaf or serious difficulty hearing, benefiting from, for example, American Sign Language, CART, hearing aids, a cochlear implant and/or other supports
20- Blind or serious difficulty seeing even when wearing glasses
31- Missing extremities (arm, leg, hand and/or foot)
40- Significant mobility impairment, benefiting from the utilization of a wheelchair, scooter, walker, leg brace(s) and/or other supports
60- Partial or complete paralysis (any cause)
82- Epilepsy or other seizure disorders
90- Intellectual disability
91- Significant Psychiatric Disorder, for example, bipolar disorder, schizophrenia, PTSD, or major depression
92- Dwarfism
93- Significant disfigurement, for example, disfigurements caused by burns, wounds, accidents, or congenital disorders

Other Options:

01- I do not wish to identify my disability or serious health condition.
05- I do not have a disability or serious health condition.
06- I have a disability or serious health condition, but it is not listed on this form.

Other Disabilities or Serious Health Conditions:

13- Speech impairment
41- Spinal abnormalities, for example, spina bifida or scoliosis
44- Non-paralytic orthopedic impairments, for example, chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body
51- HIV Positive/AIDS
52- Morbid obesity
59- Nervous system disorder for example, migraine headaches, Parkinson's disease, or multiple sclerosis
80- Cardiovascular or heart disease
81- Depression, anxiety disorder, or other psychiatric disorder
83- Blood diseases, for example, sickle cell anemia, hemophilia
84- Diabetes
85- Orthopedic impairments or osteo-arthritis
86- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
87- Kidney dysfunction
88- Cancer (present or past history)
94- Learning disability or attention deficit/hyperactivity disorder (ADD/ADHD)
95- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome, colitis, celiac disease, dysphexia
96- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis
97- Liver disease, for example, hepatitis or cirrhosis
98- History of alcoholism or history of drug addiction (but not currently using illegal drugs)
99- Endocrine disorder, for example, thyroid dysfunction

U.S. Office of Personnel Management

SF 256
Revised October 2016
Previous editions not usable

Place disability code in the Green box

SF 256

OPTIONAL

Fill out the Red box

U.S. Office of Personnel Management
Guide to Personnel Data Standards

ETHNICITY AND RACE IDENTIFICATION

(Please read the Privacy Act Statement and instructions before completing form.)

Name (Last, First, Middle Initial)	Social Security Number	Birthdate (Month and Year)

Agency Use Only

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ Yes ☐ No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
☐ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ Black or African American	A person having origins in any of the black racial groups of Africa.
☐ Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

Answers the Q's in the Green box

SF 181

OPTIONAL – AVAILABLE FOR ALL EMPLOYEES

Fill out the Red box

Department: **DoD**
Bureau: **NGB**
Division: **ORNG**

Sign & date

List any beneficiary info in the Green box

TWO witness signatures are required in the Blue box

Designation of Beneficiary

Unpaid Compensation of Deceased Civilian Employee

Important: Read all instructions before

A. Identification

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

Department or agency in which presently employed *(or former department or agency)*:

Department or agency	Bureau	Division	Location *(City, state and ZIP code)*

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any **unpaid compensation** due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) I expressly change or revoke it in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary

Date of designation *(mm, dd, yyyy)*	Your signature	Total = %

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Number and street	City, state and ZIP code
Signature of witness	Number and street	City, state and ZIP code

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received	Signature	Date

Type or print your return address to insure return

U.S. Office of Personnel Management
5 CFR 178

NSN 7540-00-634-4340

Part 1 - Original

1152-

November 1991 edition usable until September 2002. All previous editions are not usable.

Standard Form 1152
Revised June 2002

SF 1152

Fill out the Red box

Department: **DoD**
Bureau: **NGB**
Division: **ORNG**

Sign & date

OMB Approval 3206-0173

CSRS Civil Service Retirement System

Designation of Beneficiary

Civil Service and Federal Employees Retirement Systems

Important: Read all instructions before filing this form.

FERS Federal Employees Retirement System

A. Identification

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

Place an "X" in the appropriate box: ☐ An employee ☐ Retired or an applicant for retirement ☐ Former employee eligible for retirement in the future

If you are retired, give your claim number **CSA**

Department or agency in which presently employed *(or former department or agency)*:
Department or agency | *Location (city, state and ZIP code)*

Name of your retirement system ☐ CSRS ☐ FERS

Civil Service Retirement System (CSRS)

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under CSRS after my death. I understand that this designation of beneficiary will not affect the rights of any survivors who may qualify for annuity benefits after my death, cancels any previous designation of beneficiary, and remains in effect until I cancel it in writing by filing a new designation form.

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

Properly completed designations for ***CSRS employees and retirees*** are not valid unless the Office of Personnel Management (OPM) receives the form before the death of the designator. Mail both the completed Original and Employee copies of the SF 3102 to OPM, P.O. Box 45, Boyers, PA 16017.

For current CSRS employees, OPM will validate both completed copies of the form and send you a copy for your records. Your employing agency does not maintain this form.

Federal Employee Retirement System (FERS)

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under FERS after my death, including lump-sum death benefits which may become payable based on amounts contributed to CSRS before I became covered by FERS. I understand that this designation of beneficiary cancels any previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing by filing a new designation form or I receive payment of my FERS retirement contributions.

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

Properly completed designations for ***FERS employees*** are not valid unless the employing agency receives them before the death of the designator. ***FERS retirees*** must send the designation form to OPM, P.O. Box 45, Boyers, PA 16017 before the death of the designator for this form to be valid.

For current FERS employees, the agency will keep the original copy in your Official Personnel Folder and send it to OPM after you separate from Federal service.

B. Information Concerning Beneficiaries *(See Examples on the Reverse of Part 1. Type or print clearly)*

First name, middle initial, and last name of each beneficiary*	Address *(including ZIP code)* of each beneficiary**	Relationship to you*	Share to be paid to each beneficiary

Date of designation *(mm/dd/yyyy)*	Your signature	***Total = 100%***

C. Witness *(A witness is not eligible to receive a payment as a beneficiary)*:

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Address *(including ZIP code)*
Signature of witness	Address *(including ZIP code)*

Receiving Agency Certification: I have reviewed this designation and certify that the designated shares total 100% and that the witness was not designated as a beneficiary.

Date received by agency (mm/dd/yyyy)	*Signature*	*Date (mm/dd/yyyy)*

* We will pay to the person you designate, even if that person's name or relationship to you changes after you file this designation. For example, suppose you designate your spouse and then you divorce and you marry someone else. We will pay any lump sum to your former spouse unless you submit another designation to cancel prior designations or to designate who we are to pay.

** We will write to the address you provide here to contact the person you designate. However, that person is obligated to contact us after your death to apply for any death benefits that may be payable.

Type or print your return address so that we can return a copy to you.

See back of ***Employee Copy*** for instructions on where to file this form. *(Retain until the FERS employee leaves Federal service and then send to the Office of Personnel Management.)*

For current CSRS employees - - both copies must be sent to OPM.

U.S. Office of Personnel Management
5 CFR 843.205

Part 1 - Original Copy

This revision combines and supersedes all prior versions of SF 2808 and SF 3102

Standard Form 3102
Revised October 2022

PRINT SAVE CLEAR

SF 3102

OPTIONAL – ONLY AVAILABLE FOR INDEFINITE, CONDITIONAL, & PERMANENT

List any beneficiary info in the Green box

TWO witness signatures are required in the Blue box.

Fill out the Red box

Department: **DoD**
Bureau: **NGB**

OPTIONAL – ONLY AVAILABLE FOR INDEFINITE, CONDITIONAL, & PERMANENT

List any beneficiary info in the Green box

Check boxes

Sign & date

TWO witness signatures are required in the Blue box

FEGLI
Federal Employees' Group Life Insurance

Designation of Beneficiary
Federal Employees' Group Life Insurance (FEGLI) Program
(DO NOT erase or cross-out. Use a new form.)

Form Approved
OMB No. 3206-0136

Important:
Read instructions on the Back of Part 2 before completing this form.

A. Information About the Insured (not the Assignee, if there is one) (type or print)

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

The Insured is: *Place an "X" in the appropriate box.*
- [ ] an employee
- [ ] a retiree
- [ ] a compensationer

If the Insured is retired or receiving Federal Employees' Compensation, give CSA, CSI, or OWCP claim number:

Department or agency where the Insured works *(If retired, last department or agency where the Insured worked)*:

Department or agency | Bureau or division | Location *(city, state, and ZIP code)*

B. Information About the Beneficiary or Beneficiaries (See Back of Part 1 for examples) (type or print)

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated

Total (Must equal 100% or 1.0) (Do not use dollar amounts)
(Do not put a Total if you designated types of insurance. See example 4 on Back of Part 1.)

C. Statement of Insured or Assignee (type or print)

Your name and address *(Including ZIP code)*

Please check one: I am:
- [X] the Insured
- [ ] an Assignee

See Back of Part 2 for definitions

Please check all three:
- [X] I have not assigned the insurance.
- [X] Two people who witnessed my signature signed below.
- [X] I did not name either witness as a beneficiary.

I understand that if there is a valid assignment on file, only the assignee has the right to designate a beneficiary. If a valid assignment is not on file, but there is a valid court order on file with the agency or the U.S. Office of Personnel Management, as appropriate, any designation I complete for the same benefits is not valid.

I understand that if this Designation is valid, it will stay in effect unless it is canceled. (See "When Is A Designation Canceled?" on the Back of Part 2).

I understand that if this Designation is invalid for any reason, the Office of Federal Employees' Group Life Insurance will pay benefits according to the next most recent valid designation. If there isn't one, it will pay according to the order listed on the Back of Part 2.

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary(ies) named above.

Signature of Insured/Assignee *(Only the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* **This form is not valid unless the Insured/Assignee signs in this box.**

Date *(mm/dd/yyyy)*

D. Witnesses To Signature (A witness is not eligible to receive a payment as a beneficiary.)

Signature of witness | Address *(Including ZIP code)*

Signature of witness | Address *(Including ZIP code)*

E. For Agency Use Only (or OPM, as appropriate)

Receiving agency | Date of receipt *(mm/dd/yyyy)* | Signature of authorized official | Title

Part 1 - Original

U.S. Office of Personnel Management
FEGLI Handbook (RI 76-26)

Previous editions are not usable.

SF 2823
Revised May 2014

SF 2823