SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
EMPLOYEE PERMANENT RECORD

Last Name | First Name | Middle Initial | Maiden Name | Social Security Number

Address | City | State | Zip | (Area Code) Telephone

Date of Birth | Gender | E-mail Address | Cell (Area Code) Telephone

Name of person to be contacted in case of emergency | Relationship

Address | City | State | Zip | (Area Code) Telephone

Ethnic Background: This information is used for collecting statistical data and not for employment matters.
Please respond to #1 and #2 below:

#1 Ethnicity – Are you Hispanic or Latino? ☐ **Yes** ☐ **No**

#2 Race Identification – Please check up to five racial categories that apply.

☐ **American Indian or Alaska Native**	☐ **Asian-Hmong**	☐ **Asian-Other**	☐ **Hispanic**	☐ **Pacific Islander-Other**
☐ **Asian-Asian Indian**	☐ **Asian-Japanese**	☐ **Asian-Vietnamese**	☐ **Other**	☐ **Pacific Islander-Samoan**
☐ **Asian-Cambodian**	☐ **Asian-Korean**	☐ **Black**	☐ **Pacific Islander-Guamanian**	☐ **Pacific Islander-Tahitian**
☐ **Asian-Chinese**	☐ **Asian-Laotian**	☐ **Filipino**	☐ **Pacific Islander-Hawaiian**	☐ **White**

DESIGNATION OF PERSON TO RECEIVE WARRANTS OR CHECKS UPON DEATH OF EMPLOYEE: Government Code Section 53245 states that "Any person…employed by a…district…may file…a designation of a person who, notwithstanding any other provision of law, shall, on the death of the employee, be entitled to receive all warrants or checks that would have been payable to the decedent had he survived. The employee may change the designation from time to time. A person so designated shall claim such warrants or checks from the appointing power. On sufficient proof of identity, the appointing power shall deliver the warrants or checks to the claimant. A person who receives a warrant or check pursuant to this section is entitled to negotiate as if he were the payee."

In the event of my death, I hereby designate the following person, upon sufficient proof of identity, to receive all warrants or checks that would be payable to me from the Saddleback Valley Unified School District:

Name of Designee | Social Security Number

Address | City | State | Zip

In the event of my death, I hereby designate the following person as a secondary beneficiary, upon sufficient proof of identity, to receive all warrants or checks that would be payable to me from the Saddleback Valley Unified School District:

Name of Designee | Social Security Number

Address | City | State | Zip

PERMISSION TO TREAT EMPLOYEE IF UNDER 18 YEARS OF AGE _____
Parent's Signature

Please initial next to each of the following documents from the New Employee Mandatory Notices:

	(Initial Below)
Oath of Allegiance	_____
District's Policy on Sexual Harassment	_____
Penal Code Section 11166 and the District's Child Abuse Reporting Requirements Section 504 of the Rehabilitation Act of 1973	_____
District's Acceptable Use Policy: District Rules and Regulations of Technology and Computer Resources	_____
Notice of Privacy Practices	_____
Notice of COBRA information (for employees with District health benefits only) MPN Notification of Rights Material	_____
Predesignation of Personal Physician	_____
New Hire Pamphlet - Workers' Compensation	_____
Marketplace Notice	_____

CERTIFICATION: I hereby certify that I have received, read and agree to comply therewith the above-named documents as indicated by my initials above and my signature below.

Employee's Signature | Date

OFFICE USE ONLY FOR SUBSTITUTE TEACHERS

Hire Date | Position | Board Agenda Date | To Payroll Date | Assignment Code

Saddleback Valley
Unified School District

ASCIP Online Training

If you already have an account in the Syntrio system type in your e-mail address and password here: https://ascip.synlms.com/Login.

If you need to set up an account click here https://ascip.synlms.com/Login and click on "Register" to create an account. Use your personal e-mail address to set up your initial account.

If you forgot your password, click here https://ascip.synlms.com/Login and click on "Forgot Password?" to retrieve your password. You will receive an e-mail to reset your password.

Once you have logged in find the course number you will need to take:

Non-Supervisory Employee:

001. Mandated Reporter (All Employees)
002. SB1343: CA Preventing Workplace Harassment, Employees (Non-Supervisory Employees)
014. Bloodborne Pathogens (All Employees)

- Click on Catalog (blue box on right side of screen)
- Click on search bar (upper right side of screen
- Type in 001, 002, or 014
- Click on Search button
- Click on the course link
- Click Take Course

Supervisory Employee:

001. Mandated Reporter (All Employees)
003. AB1825: Workplace Harassment Prevention Version 1 (Supervisory Employees)
014. Bloodborne Pathogens (All Employees)

- Click on Catalog (blue box on right side of screen)
- Click on search bar (upper right side of screen
- Type in 001, 003, or 014
- Click on Search button
- Click on the course link
- Click Take Course

If you are unable to complete the course, please click EXIT in the upper right hand corner, and click yes to save your place. To start where you left off, follow the directions above to find the course, the system will ask if you would like to resume where you left off. Click Yes.

Once you have completed the course. You will need to print your certificate of completion and submit it to your District.

If you need assistance, please contact Kimberly Kennedy with ASCIP at (562) 404-8029 or kennedy@ascip.org.

Workplace Harassment Training

If this is your first visit to the Syntrio system, please set up your account here: https://ascip.synlms.com/Login

If you have already set up an account in Syntrio system but forgot your password, type in your email address here: https://ascip.synlms.com/Login and choose forgot password. You will receive an email to reset your password.

To find the course:

- Click Catalog
- Click in the search bar
- Search: scomp150
- Scroll down, click on the course ID (scomp150) or the title (003.AB 1825: Workplace Harassment Prevention
- Click Take Course in the upper right hand corner

If you are unable to complete the course, please click EXIT in the upper right hand corner, and click yes to save your place. To start where you left off, click Catalog, click Search and Manage Catalog, click on the course id or the title, click Take Course in the upper right hand corner, and click begin.

Once you have completed the course(s), the administrator at your District will not receive a notification. You will need to save or print your certificate of completion and submit it to your District. Click My Training, click Transcript, click the certificate icon on the right hand side for the correct training, save or print, and submit.

If you have any issues with audio, or video, please contact Anastasia Ryan at 949-580-3426.

If you need assistance, please contact Kimberly Kennedy with ASCIP at (562) 404-8029 or kennedy@ascip.org.

System Specifications

OPERATING SYSTEMS	WEB BROWSERS
• Windows XP SP 1 or higher • Windows 7 • Windows 8.1 • Windows 10 or higher • OS/9 - Users must use Netscape or Internet Explorer • OS/X - Users can use Safari, Fire Fox or Internet Explorer	• Internet Explorer 8.0 or higher. • MS Edge • Safari • Google Chrome can be used • Firefox can be used (not supported).

OTHER INFORMATION
Are cookies required? Yes Browsers allow execution of JavaScript? Yes Disable pop- up blocker? Yes **Adobe Flash Player Version 10.0 or higher for very limited number of courses in Flash.**

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT

EXPLANATION OF SOCIAL SECURITY NOTICE

Saddleback Valley Unified School District is required to provide you this notice, Form SSA-1945, to read and sign at the beginning of your employment with our school district. We are required to do so under federal law, Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004.

This notice must be provided to you because you are serving in a job or position, in which you as the employee and Saddleback Valley Unified School District as the employer will not be contributing to Social Security on your behalf.

You must do the following:

- Read the notice, Form SSA-1945
- Sign the notice, Form SSA-1945
- Return the Form SSA-1945 with your pre-employment materials to Personnel Services

What is the purpose of the notice?

The purpose of the notice is to inform you about how Social Security law may impact public employees who work in positions not covered by Social Security. This can be a complicated issue, so we encourage you to seek out additional information to determine whether the laws mentioned in the notice pertain to you by checking with the Social Security website at www.socialsecurity,gov.

Why will I not be in Social Security?

Not all employees working in government positions are required to be in Social Security. Instead of being in Social Security, you are provided a retirement program through either State Teachers Retirement System (STRS) for teachers and other certificated staff or through Public Agency Retirement Services (PARS-ARS) for part-time and substitute employees.

SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
FORM SSA-1945

NOTICE CONCERNING YOUR EMPLOYMENT IN A JOB NOT COVERED BY SOCIAL SECURITY

Employee Name:_____ Social Security #_____-_____-_____

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

Windfall Elimination Provision
Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is $313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to the Social Security publication, "Windfall Elimination Provision."

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

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

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

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

_____ _____

Signature of Employee **Date**

California School Employee: Tuberculosis (TB) Risk Assessment

Job-related requirement for child care, pre-K, K-12, and Volunteers

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.
- The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading disease.
- **Do not repeat testing** unless there are **new risk factors since the last negative test**.
- Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

The law requires that a health care provider administer this risk assessment. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. Any person administering this risk assessment is to have training in the purpose and significance of the risk assessment and Certificate of Completion.

Name of Employee/Volunteer Assessed for TB Risk Factors: _____

☐ **Classified** ☐ **Certificated** **Employee PIN:** _____

Date of assessment/examination: _____ mo/_____day/_____year **Date of Birth:** _____ mo/_____day/_____year

History of Tuberculosis Infection or Disease (Check appropriate box below)

☐ **Yes** If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.

☐ **No** (Assess for Risk Factors for Tuberculosis using information below)

TB testing is recommended if any of the 3 boxes below are checked.

☐ **One or more signs and symptoms of TB disease**
- TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.

☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month
- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.

☐ **Close contact** to someone with infectious TB disease at any time.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

_____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 10/31/2022

►START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

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	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

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

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

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*		Expiration Date *(if any) (mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any) (mm/dd/yyyy)*				

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear 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.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name
		Saddleback Valley Unified School District

Employer's Business or Organization Address (*Street Number and Name*)	City or Town	State	ZIP Code
25631 Peter A. Hartman Way	Mission Viejo		

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			**B.** Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date *(if any) (mm/dd/yyyy)*

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security
		8. Native American tribal document		
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to the instructions for more information about acceptable receipts.

Recipient Designation Form–Information

One-Time Death Benefit/Cash Balance Lump-Sum Payment

To be valid, this form must be received and accepted by CalSTRS before your death.

The *Recipient Designation* form replaces the *One-Time Death Benefit Recipient* form and the *Cash Balance Beneficiary Designation* form. If you have one of these forms currently on file with CalSTRS, you do not need to submit a new *Recipient Designation* form unless you wish to make a change to your recipient designation.

DEFINED BENEFIT PROGRAM MEMBERS

Use this form to designate recipients to receive the one-time benefit that may be payable in the event of your death. If you are an active member at the time of your death, any accumulated contributions in your account will be paid to your designated recipients only if you did not elect an option beneficiary to receive a continuing benefit after your death, or you have no spouse, registered domestic partner or children eligible to receive a family or survivor benefit allowance after your death.

If your death occurs before retirement, your recipients may be eligible to receive the balance in your Defined Benefit Supplement account as an ongoing annuity or a lump-sum payment. If your death occurs after retirement, your recipients may be eligible for the ongoing annuity you elected at retirement.

This form will not protect your survivor with a lifetime benefit. To provide your survivors with a lifetime benefit, submit the *Preretirement Election of Option* form when you are eligible to retire.

CASH BALANCE BENEFIT PROGRAM PARTICIPANTS

Use this form to designate recipients to receive the benefit in the event of your death.

If you are receiving an annuity at the time of your death, the benefit payable is determined based on the annuity you elected.

If your recipient's (other than an entity) share of your account balance is at least $3,500, he or she may elect to receive an annuity in place of a lump-sum payment.

IMPORTANT FACTS

- This form remains in effect until either you submit another valid *Recipient Designation* form, or your membership in CalSTRS is terminated by a refund of your accumulated contributions. *It is important to keep this form current.*
- If your designated primary recipients predecease you, any benefit due will be paid to your secondary recipients, unless you submit a valid *Recipient Designation* form designating new recipients. If we are unable to locate your designated recipients, the death benefit will be distributed to the best of our ability according to the laws in existence at the time of your death.
- If you do not have a valid *Recipient Designation* form on file with CalSTRS before your death or if all your designated recipients predecease you, any benefit due will be paid to your estate.
- You may change your recipient designations at any time—before or after retirement. There is no fee or financial penalty for changing your designation.

QUESTIONS

E-mail us at CalSTRS.com/contactus or call 800-228-5453.

This form is available at CalSTRS.com (select *Forms & Publications*).

Return your completed form to:

CalSTRS
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275

Recipient Designation Form–Instructions

One-Time Death Benefit/Cash Balance Lump-Sum Payment

Print clearly in dark ink or type all information requested. Initial all corrections on the form.

Check the appropriate box to identify your CalSTRS membership status.

If you are both a Defined Benefit Program member and Cash Balance Benefit Program participant and you are designating different recipients for each, you must complete two separate *Recipient Designation* forms.

SECTION 1: MEMBER/PARTICIPANT INFORMATION

Enter your full name, Client ID or Social Security number, complete mailing address, birth date, telephone number and e-mail address.

SECTIONS 2 AND 3: PRIMARY AND SECONDARY RECIPIENTS OR TRUST

You may name a living person, an estate, a trust, a corporation, a charitable organization, a parochial institution or a public entity as your recipient.

- **Persons—**Provide full name, address, telephone number, Social Security number, birth date and relationship.
- **Organization—**To designate an organization, check the box and enter the name and address of the organization and the organization's tax identification number. Include organization contact information whenever possible.
- **Trust—**To designate a trust, check the box and enter the full name of the trust, the trustee's name and address, and the date the trust was created. CalSTRS will contact the trustee and pay benefits to the trust. You do not need to provide the trust document at this time.
- **Estate—**To designate your estate, check the box and enter "My Estate" for the recipient's name. Upon your death, if your estate is not subject to probate, CalSTRS will pay benefits pursuant to California Probate Code section 13101.

Check the box on page 3 if additional recipients are listed on an attachment. Identify each as *primary* or *secondary.*

You may designate a percentage for each recipient. If you use percentages, the total must equal 100 percent for the primary recipient section and/or secondary recipient section.

SECTION 4: REQUIRED SIGNATURES

You must sign and date your form. If you are married or registered as a domestic partner, your spouse or partner must also sign and date your form acknowledging your recipients and provide his or her Social Security number and date of birth.

If your spouse or registered domestic partner does not sign your form, you must complete the *Justification for Non-Signature of Spouse or Registered Domestic Partner.*

Failure to have the required signatures will result in the rejection of your *Recipient Designation* form.

If you divorced or terminated a registered domestic partnership and a portion of your CalSTRS benefits was awarded to a former spouse or partner, check the box that indicates this. You may need to refer to your settlement agreement. In addition, if your court documents have not been reviewed by CalSTRS, you may be asked to provide them.

Recipient Designation Form

One-Time Death Benefit/Cash Balance Lump-Sum Payment

(MS 0002, rev. 01/11)

CalSTRS
California State Teachers' Retirement System
P.O. Box 15275, MS 43
Sacramento, CA 95851-0275
800-228-5453
CalSTRS.com

This form is for designating recipients to receive the death benefits payable in the event of your death under the CalSTRS Defined Benefit Program and the Cash Balance Benefit Program. Print clearly in dark ink or type all information requested and initial any corrections.

Check one of the following:

- ■ I am a member of the Defined Benefit Program. My recipient designation is for the one-time death benefit payable upon my death.
- ☐ I am a participant of the Cash Balance Benefit Program. My recipient designation is for the lump-sum payment to be distributed upon my death.
- ☐ I am a member/participant of both the Defined Benefit and Cash Balance programs. My recipient designation is for the lump-sum death benefits payable under both programs. (Refer to instructions if recipients are different between programs.)

I hereby revoke any previous designations and designate the following primary recipients—or their survivors—to receive equal amounts, unless otherwise specified as recipients for any benefits payable under the Teachers' Retirement Law at the time of my death. If I survive the primary recipients, I designate the secondary recipients—or their survivors—to share equally unless otherwise specified as recipients for any benefits under law at the time of my death. If I survive all of my named recipients, then any benefit payable at the time of my death will be paid to my estate. I understand this form does not designate a recipient to receive a continuing monthly retirement benefit.

Return your signed form to: CalSTRS • P.O. Box 15275, MS 43 • Sacramento, CA 95851-0275

Section 1: Member/Participant Information

NAME (LAST, FIRST, INITIAL) | CLIENT ID OR SOCIAL SECURITY NUMBER

MAILING ADDRESS | DATE OF BIRTH (MM/DD/YYYY)

CITY | STATE | ZIP CODE | ( ) HOME TELEPHONE

E-MAIL ADDRESS

Section 2: Primary Recipients

Use this area to designate one or more *primary* recipients to receive a death benefit.
Use additional sheets if needed.

FULL NAME OF PERSON, TRUST OR ORGANIZATION

MAILING ADDRESS | ( ) TELEPHONE

CITY | STATE | ZIP CODE

☐ Person – Relationship: _____
☐ Male ☐ Female

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TAXPAYER ID NUMBER/EMPLOYER ID NUMBER

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)

PERCENTAGE
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

MS0002

CALSTRS

Section 2: Primary Recipients continued

FULL NAME OF PERSON, TRUST OR ORGANIZATION

MAILING ADDRESS ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship: _____
☐ Male ☐ Female
☐ Organization – Contact Name: _____
☐ Trust
☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)

PERCENTAGE
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

FULL NAME OF PERSON, TRUST OR ORGANIZATION

MAILING ADDRESS ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship: _____
☐ Male ☐ Female
☐ Organization – Contact Name: _____
☐ Trust
☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)

PERCENTAGE
(MUST TOTAL 100% FOR ALL PRIMARY RECIPIENTS)

Section 3: Secondary Recipients

Use this area to designate one or more *secondary* recipients to receive a death benefit should all of your primary recipients predecease you. Use additional sheets if needed.

FULL NAME OF PERSON, TRUST OR ORGANIZATION

MAILING ADDRESS ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship: _____
☐ Male ☐ Female
☐ Organization – Contact Name: _____
☐ Trust
☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)

PERCENTAGE
(MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)

CALSTRS

Section 3: Secondary Recipients continued

FULL NAME OF PERSON, TRUST OR ORGANIZATION

MAILING ADDRESS ( ) TELEPHONE

CITY STATE ZIP CODE

☐ Person – Relationship:_____
☐ Male ☐ Female

☐ Organization – Contact Name: _____

☐ Trust

☐ Estate

SOCIAL SECURITY NUMBER/TIN/EIN

DATE OF BIRTH/TRUST DATE (MM/DD/YYYY)

PERCENTAGE
(MUST TOTAL 100% FOR ALL SECONDARY RECIPIENTS)

☐ **Check this box if additional recipients are listed on an attachment. Identify each as *primary* or *secondary*.**

Section 4: Required Signatures

Check all that apply.

- ☐ I am married or registered as a domestic partner and both our signatures are below.
- ☐ I am married or registered as a domestic partner and my spouse or partner did not sign below. I have completed and signed the *Justification for Non-Signature of Spouse or Registered Domestic Partner* section on the next page.
- ☐ I have never been married or in a registered domestic partnership, or I am widowed or my partner has died.
- ☐ I have been divorced or terminated a registered domestic partnership and my former spouse or partner was awarded a portion of my CalSTRS benefits.
- ☐ I have been divorced or have terminated a registered domestic partnership and my former spouse or partner was *not* awarded a portion of my CalSTRS benefits.

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it may result in penalties, including restitution, up to one year in jail and a fine of up to $5,000 (Education Code section 22010).

MEMBER'S SIGNATURE DATE (MM/DD/YYYY)

SPOUSE'S OR REGISTERED DOMESTIC PARTNER'S SIGNATURE DATE (MM/DD/YYYY)

SPOUSE'S OR PARTNER'S NAME (LAST, FIRST, INITIAL)

SPOUSE'S OR PARTNER'S SOCIAL SECURITY NUMBER SPOUSE'S OR PARTNER'S DATE OF BIRTH (MM/DD/YYYY)

CALSTRS
HOW WILL YOU SPEND YOUR FUTURE?

Justification for Non-Signature of Spouse or Registered Domestic Partner

As required by Education Code sections 22453 and 26703, any request related to the selection of benefits by a member in which spousal or registered domestic partner interest may be present requires the signature of the spouse or registered domestic partner unless one of the following conditions exist. If you are married or registered as a domestic partner and your spouse or partner does not sign this form, you must check the appropriate box indicating the reason your spouse or partner did not sign.

- ☐ I do not know and have taken all reasonable steps to determine the whereabouts of my spouse or registered domestic partner.
- ☐ My spouse or registered domestic partner is incapable of executing the acknowledgment because of an incapacitating mental or physical condition.
- ☐ My current spouse or registered domestic partner has no identifiable community property interest in the benefits.
- ☐ My spouse or registered domestic partner and I have executed a settlement agreement that makes the community property law inapplicable to the marriage or registered domestic partnership.
- ☐ My spouse or registered domestic partner has refused to sign the acknowledgment. Court action will be or has been initiated to enforce or waive the signature requirement for my spouse or partner. (CalSTRS must have a certified copy of the court order before any designation can be made. Submit a certified copy of the court order when you receive it.) Education Code sections 22454 and 26704

I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. I understand that perjury is punishable by imprisonment for up to four years (Penal Code section 126).

I understand it is a crime to fail to disclose a material fact or to make any knowingly false material statements for the purpose of altering a benefit administered by CalSTRS and it may result in penalties, including restitution, up to one year in jail and a fine of up to $5,000 (Education Code section 22010).

MEMBER'S SIGNATURE _____ SIGNATURE DATE (MM/DD/YYYY) _____

If this form is not completely filled out, it will not be accepted and will be returned to you. Your current recipient status will not be updated. Review your form carefully before submitting:

- ☐ Did you designate at least one primary recipient and provide all the requested information?
- ☐ If you designated a trust, did you provide the name and date the trust was created? Do not provide your trust document at this time.
- ☐ If you designated percentages, do they equal 100 percent for your primary recipients and/or secondary recipients?
- ☐ Did you sign and date the form?
- ☐ If you are married or in a registered domestic partnership, did your spouse or partner sign and date the form?
- ☐ If you cannot obtain your spouse or partner's signature, did you complete, sign and date the *Justification for Non-Signature of Spouse or Registered Domestic Partner*?

SVMTA

SADDLEBACK VALLEY MANAGEMENT TEAM ASSOCIATION

25631 Peter A. Hartman Way, Mission Viejo, CA 92691

MEMBERSHIP FORM

NAME: _____

EMPLOYEE PIN #: _____

POSITION: _____

CERTIFICATED: ☐

CLASSIFIED: ☐

PAYMENT OPTIONS:

_____ I hereby authorize the Saddleback Valley Unified School District to deduct $11.00 per month for 10 months for the purpose of fulfilling the membership dues requirements of $110 yearly.

_____ I have enclosed a check for $110 to fulfill my membership dues for one year.

Should the dues of the Association be changed by appropriate action of the Board of Directors, the membership shall be notified by the Board of Directors, and this authorization shall constitute a directive to the District to deduct the established dues as adopted by the Board.

_____ _____

Signature Date

Please return to Tiffani Volpe in Accounting