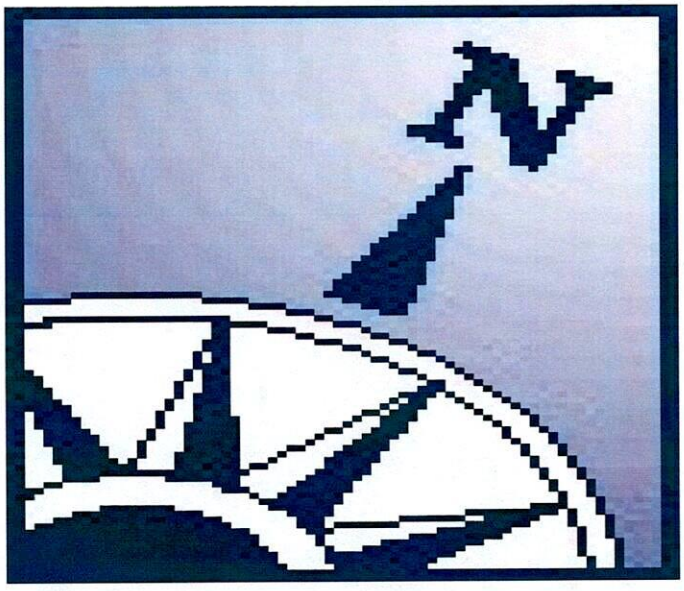
May 29, 2024

North Salem Central School District



ALL ABOUT YOUR PAYROLL

Fiscal Year 2024-2025
Payroll Information & Forms

For Employees of the
North Salem Central School District

27 Pages

Table of Contents

NORTH SALEM
Central School District

Duncan Wilson Ed. D.
Superintendent of Schools

Office of Business Administration

Time Sensitive Information

Important Info:

- **First pay in September will be a live check. The first check will be available in the main office of your building location to sign for.**
- **Payroll Calendar** is attached. Please read the options for distribution of paychecks while school is not in session.

Health Insurance Open Enrollment Period

- **June 1, 2024 - June 30, 2024** is open enrollment for the health care plan. If you are making changes please contact me, and I will forward you the form. You will need to return the form to me **NO LATER THAN June 20, 2024** for a **July 1, 2024** effective date.

Qualifying Event

- Please continue to be aware that any qualifying event such as marriage, divorce, birth of a child etc., may change your (or your dependents) insurance eligibility. You have **30 days** from date of the event to contact the business office to make any changes to your insurance, such as adding/removing dependents.

Personnel Information Sheet

- For all employees, the **Personnel Information Sheet** must be signed and returned to Julie Mastrantoni in the Business Office by **06/20/24** *only if there are changes.*

Required annually if you choose to participate in the following:

Health Insurance Buyout:

- For all NSPA employees, CSEA employees, NSTA employees, and SRP employees, the **Waiver of Health Insurance Form** must be signed and returned to Julie Mastrantoni in the Business Office by **6/20/24. Proof of Health Insurance Coverage must be attached.**

Flex Spending: The Preferred Group

- For all employees, **6/1/24** through **6/30/24** is the Open Enrollment for Section 125 Flexible Spending Benefit Plan, the plan begins **7/1/24.** The Information Sheets and Enrollment Application are attached. **The Enrollment Application** must be signed and returned to Julie Mastrantoni in the Business Office by **6/17/24** to allow adequate processing time of your changes.

Pay Options for 10 month Employees

- Mandatory for all 10 month employees, please fill out the pay options sheet and return to Julie Mastrantoni in the Business Office by **6/20/24.**

Review your financial information annually

- Please remember to review important financial information annually such as your beneficiaries and your federal and state withholdings. Designation of beneficiary forms are attached for TRS, ERS, and JJ Stanis.

If you have any questions, please contact Julie Mastrantoni at jmastrantoni@northsalemschools.org

NORTH SALEM CENTRAL SCHOOL DISTRICT
2024-2025 School Calendar

September 2024						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October 2024						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November 2024						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

December 2024						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January 2025						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February 2025						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

SEPTEMBER
9/2 Labor Day
9/3&4 Superintendent's Conference Day
9/5 Schools Open

Total Days: 18 student
2 Supt. Conference Day

OCTOBER
10/3-4 Rosh Hashanah (Sunset of 10/2 – 10/4)
Yom Kippur (Sunset of 10/11 – 10/12)
10/14 Columbus Day/Indigenous Peoples Day
10/28 ½ PD Early Dismissal
Total Days: 20 student

NOVEMBER
11/11 Veterans Day
11/21 PQ Parent/Teacher Conf.
11/28-29 Thanksgiving Recess

Total Days: 18 student

DECEMBER
12/5 MS/HS Parent/Teacher Conf
12/23-31 Holiday Recess

Total Days: 15 student

JANUARY
1/1 Holiday Recess
1/13 ½ PD Early Dismissal
1/20 Martin Luther King Day
1/29 Asian Lunar New Year

Total Days: 20 student

FEBRUARY
2/17-19 Winter Recess
2/20&21 PD Days

Total Days: 15 student
2 PD Days

March 2025						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

April 2025						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

May 2025						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

June 2025						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

NOTE:
Weather make-up days to be taken in the following order: 4/14, 4/15, 4/16, 4/17

Adopted: February 7, 2024

MARCH

Total Days: 21 student
½ PD Day

APRIL
4/10 PQ Parent/Teacher Conf
4/14-18 Spring Recess
(Good Friday 4/18, Easter 4/20, Passover – Sunset of 4/12-4/20)

Total Days: 17 student

MAY
5/26 Memorial Day Recess

Total Days: 21 student

JUNE
6/19 Juneteenth
6/26 Last Day for Students
6/27 PD Day/Rating Day

Total Days: 18 student
1 Supt. Conference Day

182 MS/HS Student Days
+ 2 Superintendent's Conference Days
+ 3 Professional Development Days
+ 1 Parent/Teacher Conference Day
188

181 PQ Student Days
+ 2 Superintendent's Conference Days
+ 3 Professional Development Day
+ 2 Parent/Teacher Conference Days
188

School Closed
Supt Conf/PD Days No Students
Early Dismissal
Parent Teacher Conferences

North Salem Payroll Calendar for 2024/2025

PAYROLL #	PAY DATE	PAYROLL #	PAY DATE
1	07/12/24	14	01/10/25
2	07/26/24	15	01/24/25
3	08/09/24	16	02/07/25
4	08/23/24	17	02/21/25
5	09/06/24	18	03/07/25
6	09/20/24	19	03/21/25
7	10/04/24	20	04/04/25
8	10/18/24	21	04/18/25
9	11/01/24	22	05/02/25
10	11/15/24	23	05/16/25
11	11/29/24	24	05/30/25
Health Waiver	12/06/24	Health waiver	06/06/25
12	12/13/24	25	06/13/25
13	12/27/24	26	06/27/25

07/12/24	First full pay for 12 month employees
9/6/24	Live check that will need to be picked up at the main office of your building
09/06/24	First full pay for ten month employees will be a live check (1/22nd or 1/26th of your annual salary depending on the option you choose on the salary agreement)
12/06/24	Health waiver payments
06/06/25	Health waiver payments
06/27/25	Final pay for ten & twelve month employees
06/27/25	Lump sum check for ten month staff selecting this option

To calculate bi-weekly 12 month employees pay, use the annual salary divided by 26

Annual deductions will be divided by 22 for ten month staff and 26 for twelve month staff.

*** Options for paychecks during scheduled holiday:**

1.Sign up for Direct Deposit at least one month prior to effective date of payroll.

2.Upon written request from an employee, the check will be mailed.

3.Pick up check during the regular distribution following return from recess.

Time Sheet Calendar for 2024/2025		
Pay Period	Time Sheets Received By (In payroll office)	Pay Date
June 16, 2024 – June 29, 2024	July 3, 2024	July 12, 2024
June 30, 2024 - July 13, 2024	July 17, 2024	July 26, 2024
July 14, 2024 - July 27, 2024	July 31, 2024	August 9, 2024
July 28, 2024 - August 10, 2024	August 14, 2024	August 23, 2024
August 11, 2024 - August 24, 2024	August 30, 2024	September 6, 2024
August 25, 2024 - September 7, 2024	September 11, 2024	September 20, 2024
September 8, 2024 - September 21, 2024	September 25, 2024	October 4, 2024
September 22, 2024 - October 5, 2024	October 9, 2024	October 18, 2024
October 6, 2024 - October 19, 2024	October 23, 2024	November 1, 2024
October 20, 2024 - November 2, 2024	November 6, 20234	November 15, 2024
November 3, 2024 - November 16, 2024	November 20, 2024	November 29, 2024
November 17, 2024 – November 30, 2024	December 4, 2024	December 13, 2024
December 1, 2024 - December 14, 2024	December 18, 2024	December 27, 2024
December 15, 2024 - December 28, 2024	January 1, 2025	January 10, 2025
December 29, 2024 - January 11, 2025	January 15, 2025	January 24, 2025
January 12, 2025 - January 25, 2025	January 29, 2025	February 7, 2025
January 26, 2025 - February 8, 2025	February 12, 2025	February 21, 2025
February 9, 2025 - February 22, 2025	February 26, 2025	March 7, 2025
February 23, 2025 - March 8, 2025	March 12, 2025	March 21, 2025
March 9, 2025 - March 22, 2025	March 26, 2025	April 4, 2025
March 23, 2025 - April 5, 2025	April 9, 2025	April 18, 2025
April 6, 2025 - April 19, 2025	April 23, 2025	May 2, 2025
April 20, 2025 -May 3, 2025	May 7, 2025	May 16, 2025
May 4, 2025 - May 17, 2025	May 21, 2025	May 30, 2025
May 18, 2025- May 31, 2025	June 4, 2025	June 13, 2025
June 1, 2025 - June 14, 2025	June 18, 2025	June 27, 2025

***Please note this assumes that all information is accurate, and ready for processing. There is a lag in processing time sheets. All time sheets and/or time clock punches must be approved by the appropriate Administrator/Supervisor to ensure timely processing. Time sheets/time clock additional hours/overtime from June 15, 2025-June 30, 2025 will be processed in July.

NORTH SALEM CENTRAL SCHOOL DISTRICT
PERSONNEL INFORMATION
2024/2025

Please return only if you have made changes.

PLEASE PRINT

NAME: _____

MAILING ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

PERSONAL E-MAIL: _____

MARITAL STATUS: _____

EMERGENCY CONTACT INFORMATION

Please indicate below who should be contacted in the event of an emergency.

NAME: _____ RELATIONSHIP: _____

TELEPHONE: _____ CELL PHONE: _____

NAME: _____ RELATIONSHIP: _____

TELEPHONE: _____ CELL PHONE: _____

PERTINENT MEDICAL INFORMATION (OPTIONAL)

_____

_____

_____

_____

EMPLOYEES'S SIGNATURE: _____ **DATE:** _____

NORTH SALEM
Central School District

Duncan Wilson Ed. D.
Superintendent of Schools

Office of Business Administration

Civil Service Employees Association

NORTH SALEM CSD
WAIVER OF HEALTH INSURANCE BENEFITS
Please see your respective contract

(To be completed annually)

DISTRICT INSURANCE WILL BE CANCELLED AS OF 7/1/2024

Employee Name: _____

1) _____ I am eligible for family coverage because I have dependents that qualify for such coverage, but I elect to waive my family coverage because I have coverage elsewhere. I understand that I will receive a non-salary payment equal to $4,000, payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

2) _____ I elect to waive individual health insurance because I am eligible for individual plan, and have coverage elsewhere. I understand that I will receive a non-salary payment equal to $2,000, payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

Employee Signature: _____

Date: _____

Policyholder of accessible coverage: _____

Relationship to Employee: _____

Policy # of Policyholder: _____

Insurance Company providing coverage: _____

Please attach proof of Health Insurance Coverage.

IMPORTANT INFORMATION

1. A unit member eligible for District provided hospitalization and major medical benefits may waive all coverage to which he/she would otherwise be entitled so long as he/she is eligible for dependent care coverage on another policy
2. You are NOT required to sign this waiver. You should consider your own and your family's medical needs, financial resources, and other health coverage before making any decision.
3. If you decide to take advantage of the waiver option, you will NOT be able to change your mind until the end of the school year, except for catastrophic reasons, and then only if the District's health and hospitalization carrier will allow it.

NORTH SALEM
Central School District

Duncan Wilson Ed. D.
Superintendent of Schools

Office of Business Administration

North Salem Principals' Association

NORTH SALEM CSD
WAIVER OF HEALTH INSURANCE BENEFITS
Please see your respective contract

(To be completed annually)

DISTRICT INSURANCE WILL BE CANCELLED AS OF 7/1/2024

Employee Name: _____

1) _____ I am eligible for medical coverage because I have dependents that qualify for such coverage, but I elect to waive my family coverage because I have coverage elsewhere. I understand that I will receive a non-salary payment equal to $4,000, payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

Employee Signature: _____

Date: _____

Policyholder of accessible coverage: _____

Relationship to Employee:_____

Policy # of Policyholder: _____

Insurance Company providing coverage: _____

Please attach proof of Health Insurance Coverage.

IMPORTANT INFORMATION

1. An administrator eligible for District provided hospitalization and major medical benefits may waive all coverage so long as he/she is eligible for dependent coverage on another policy.
2. You are NOT required to sign this waiver. You should consider your own and your family's medical needs, financial resources, and other health coverage before making any decision.
3. If you decide to take advantage of the waiver option, you will NOT be able to change your mind until the end of the school year, except for catastrophic reasons, and then only if the District's health and hospitalization carrier will allow it.

NORTH SALEM
Central School District

Duncan Wilson Ed. D.
Superintendent of Schools

Office of Business Administration

North Salem Teachers' Association

NORTH SALEM CSD
WAIVER OF HEALTH INSURANCE BENEFITS
Please see your respective contract

(To be completed annually)

DISTRICT INSURANCE WILL BE CANCELLED AS OF 7/1/2024

Employee Name: _____

1) _____**Hired before July 1, 2021** - I am eligible for medical coverage because I have dependents that qualify for such coverage, but I elect to waive my family coverage because I have coverage elsewhere. I understand that I will receive a non-salary payment equal to $4,000, payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

2) _____ **Hired after July 1, 2021** - I am eligible for medical coverage because I have dependents that qualify for such coverage, but I elect to waive my family coverage because I have coverage elsewhere. I understand that I will receive a non-salary payment equal to $3,000 payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

Employee Signature: _____

Date: _____

Policyholder of accessible coverage: _____

Relationship to Employee:_____

Policy # of Policyholder: _____

Insurance Company providing coverage: _____

Please attach proof of Health Insurance Coverage.

IMPORTANT INFORMATION

1. A unit member eligible for District provided hospitalization and major medical benefits may waive all coverage so long as he/she is eligible for dependent coverage on another policy.
2. You are NOT required to sign this waiver. You should consider your own and your family's medical needs, financial resources, and other health coverage before making any decision.
3. If you decide to take advantage of the waiver option, you will NOT be able to change your mind until the end of the school year, except for catastrophic reasons, and then only if the District's health and hospitalization carrier will allow it.

NORTH SALEM
Central School District

Duncan Wilson Ed. D.
Superintendent of Schools

Office of Business Administration

School Related Professionals

NORTH SALEM CSD
WAIVER OF HEALTH INSURANCE BENEFITS
Please see your respective contract

(To be completed annually)

DISTRICT INSURANCE WILL BE CANCELLED AS OF 7/1/2024

Employee Name: _____

1) _____ I am eligible for family coverage because I have dependents that qualify for such coverage, but I elect waive my family coverage because I have coverage elsewhere. I understand that I will receive a non-salary payment equal to $4,000, payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

2) _____ I am eligible for family coverage because I have dependents that qualify for such coverage, but I wish to receive individual coverage. I understand that I will receive a non-salary payment equal to $2,000, payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

3) _____ I elect to waive individual health insurance because I am eligible for individual plan, and have coverage elsewhere. I understand that I will receive a non-salary payment equal to $2,000, payable in two equal installments. One at the end of the calendar year and one at the end of the school year.

Employee Signature: _____

Date: _____

Policyholder of accessible coverage: _____

Relationship to Employee: _____

Policy # of Policyholder: _____

Insurance Company providing coverage: _____

Please attach proof of Health Insurance Coverage.

IMPORTANT INFORMATION

1. A unit member eligible for District provided hospitalization and major medical benefits may waive all coverage to which he/she would otherwise be entitled so long as he/she is eligible for dependent care coverage on another policy

2. You are NOT required to sign this waiver. You should consider your own and your family's medical needs, financial resources, and other health coverage before making any decision.

3. If you decide to take advantage of the waiver option, you will NOT be able to change your mind until the end of the school year, except for catastrophic reasons, and then only if the District's health and hospitalization carrier will allow it.

PREFERRED PG GROUP
The Preferred Group
PO Box 15136
Albany, NY 12212-5136
(866) 989-8995

Your Account Information Is Online
www.ThePreferredGroup.com

WLT10156

North Salem CSD
PG Blue - FSA Enrollment Form

— Please Read and Fill Out Carefully. Return to payroll by 06/07/2024

DIRECTIONS: Employee — Complete Sections 1, 2, 3 and 4 then return to your employer
Employer — Complete 'Change Type' Box and complete Section 5

Section 1 Employee Information

Employer Group #	Employer Group Name	Plan Year	Social Security Number
10156	**North Salem CSD**	**7/1/2024** to **6/30/2025**	___-___-___

Employee Name (First Name) | (Last Name)

Employee Address (Street, Apt. #) | Date of Birth (mm/dd/yyyy) ___/___/___

Employee Address (City, State, Zip Code)
,

Home Phone | Cell Phone | Email Address (Please allow email from benefitsinfo@thepreferredgroup.com)

Section 2 Flexible Spending Plan Benefit Elections

Please Return to Payroll Office by Friday, June 07, 2024

Account Type		Fund#		New Election		
MEDICAL FSA	(up to $3,200 max)	1				
DEPENDENT DAY CARE	($5,000 max/$2,500 if married, filing separately)	2				
PREMIUM EXPENSE	(For privately held dental/vision insurance, no life insurance allowed)	3				

Section 3 Reimbursement Options

If you wish to have your reimbursements directly deposited to your bank account, please fill in the line below.

Direct Deposit Setup: Bank Name_____ Routing #_____ Acct #_____

Initial to Request Debit Card _____

Please note: By entering the above information you are enrolling into these specified programs and are validating your dependent information. For more information on these options including the timing of reimbursements, please see your Summary Plan Description.

Section 4 Signature and Acceptance of Rules of Flexible Spending Plan Rules

Salary Redirection Agreement (Please read and sign below): I have read and understand the explanation I have received regarding my options under this Flexible Benefits Program. I hereby apply for the options listed above and I authorize my employer to redirect my salary during the plan year as indicated. I understand that I am only entitled to the amount of the above elections and cannot change any of my elections during the plan year (unless I have an acceptable change in status), and that any money left in my account(s) at the end of the plan year will be treated in accordance with my employer's FSA plan document.

Employee Signature | Date

Section 5 Employer's Section — Payroll Information for Salary Reduction Changes

Payrolls

Fund	First Payroll Date	Last Payroll Date	YTD Deductions	Per Payroll Deduct
FSA				
DCA				
PRE				

Employer Signature | Date

Use 'First Payroll Date' and employer signature ONLY if the employee is making a *mid-year* election. Use the 'Last Payroll Date' and 'YTD Deductions' if changing an *old* election or termination.

NORTH SALEM
Central School District

Duncan Wilson Ed. D
Superintendent of Schools

Office of Business Administration

PAY OPTIONS FOR ALL TEN-MONTH EMPLOYEES
2024/2025

All 10 Month Employees must select one of the following options:

1. Twenty-two (22) payments of equal amounts.

2. Twenty-six (26) payments of equal amounts. You will receive 1/26 of your annual salary each payday, with the exception of the last check. This check will include five (5) payroll amounts, or 5/26 of your annual salary.

Please indicate your preference by checking option #1 or option #2 and return to the Payroll Department.

Option #1

_____ It is my desire to receive twenty-two (22) equal installments of my annual salary in accordance with the payroll calendar from **9/6/2024** through **6/27/2025**.

Option #2

_____ I hereby authorize NSCSD to pay 1/26 of my annual salary in accordance with the payroll calendar beginning **9/6/2024,** and to withhold any other amounts due me from my salary until the last payment on **6/27/2025**, at which time NSCSD will pay me 5/26 (or the balance) of my total salary for the year.

Print Name: _____

Employee Signature: _____

Date: _____

NORTH SALEM
Central School District

Duncan Wilson Ed. D.
Superintendent of Schools

Office of Business Administration

TAX SHELTERED ANNUITY (TSA) 403(b) INFORMATION SHEET

403(b) is a section of the Internal Revenue Code, which permits a tax-sheltered retirement program for employees of public school systems and other non-profit organizations. TSA's are managed by major insurance companies and regulated investment firms.

Twice monthly, NSCSD deducts the amount you designate from your paycheck (pre-tax) and forwards it to your chosen company. Contributions and earnings compound tax deferred until they are withdrawn, usually when the individual is in a lower tax bracket.

The IRS limits for 403(b) plans in the calendar year 2024 are:

- Regular limit: $23,000.00
- Employees age 50 and older this calendar year: $30,500.00

These limits change 1/1/2025

NSCSD acts merely as a collection agent. All annuities must be arranged with your chosen agent prior to submission to OMNI.

To start or make any changes to your contribution, you must fill out an OMNI flex form and submit it to your agent.

Both the employee and their agent must sign this form when starting a TSA or changing annuity companies.

To obtain additional printed copies of the 403(b) Flex Form and or Vendor List, go to the following website: http://www.omni403b.com

*Individual calculations required

IMPORTANT INFORMATION

North Salem Central School District neither endorses any authorized TSA vendor, nor is responsible for any investment. North Salem Central School District does not choose the annuity contract or custodial account in which your contributions are invested.
North Salem Central School District is not responsible for any investments.

NORTH SALEM CENTRAL SCHOOL DISTRICT

230 JUNE ROAD

NORTH SALEM, NY 10560

(914) 669-5414

TAX SHELTERED ANNUITY COMPANIES

MetLife
www.metlife.com
(800) 638-7732

Confidential Planning Corp
www.cpcfs.com
(800) 822-9968

Fidelity Management Trust Comp*
www.fidelity.com
(800 343-3548

AXA Equitable Life Insurance Comp
www.equitable.com
(800) 487-6669

David Lerner Associates
www.davidlerner.com
(877) 367-5960

RiverSource Life Insurance Co of NY
www.riversource.com
(800) 333-3437

ING Life Insurance & Annuity Co*
www.ing.com
(800) 677-4636

LA Hertberg Financial Services
www.ccm-ria.com
(203) 264-8282

Mutual Inc
www.mutualinc.com
(800) 624-0062

Oppenheimer Shareholders Srvcs*
www.openheimerfunds.com
(888) 470-0862

MetLife of Connecticut
www.metlife.com
(800) 638-5433

For additional companies please visit www.omni403b.com

*Mutual fund companies also

IMPORTANT INFORMATION

North Salem Central School District neither endorses any authorized TSA vendor, nor is responsible for any investment. North Salem Central School District does not choose the annuity contract or custodial account in which your contributions are vested.

OMNI&TSACG Compliance Services
Visit Us Online: https://www.omni403b.com
220 Alexander Street, Suite 400 Rochester, NY 14607 Phone: 1.877.544.6664 Fax: 1.585.672.6194

403(b) SALARY REDUCTION AGREEMENT FORM (SRA) For Tax Sheltered Annuities and Custodial Accounts

- Please supply the information requested below.
- Read all agreements on this form before submitting.
- Fields having an asterisk notation are required.

403(b)

IMPORTANT NOTICE: Before You Sign, Read All Information on this form:

A Tax Sheltered Annuity ("TSA") is an investment account that is set aside for your retirement (only), and is paid for with "pre-tax" dollars. A Custodial Account ("CA") is the group or individual custodial account or accounts, established for each Employee, by the Employer, or by each Employee individually, to hold assets of the Plan. Unless utilizing the catch-up provisions, your Maximum Allowable Contribution ("MAC") cannot exceed $23,000 ($30,500 if age 50 or over) in 2024. Both TSA & CA receive tax deferred treatment.

Part 1: Employee Information

☐ Check here if you have contributed to another 403(b), 401(a), or 401(k) plan offered by another employer in the current calendar year. **NOTE: Do not check this box if you have only contributed to the 403(b) plan associated with this SRA**. If so, please provide the amount of the year-to-date contributions you have made to the other plan(s):
$ _____ and, if applicable, the name of the other Plan: _____

* Social Security Number: _____ * First Name: _____ MI: _____ * Last Name: _____

*Address: _____

* City: _____ *State: _____ *Zip: _____

* Date of Birth: _____ * Phone: _____ *Email address: _____

Part 2: Employer Information

* Full Organization Name, City and State: _____ * Date of Hire: (mm/dd/yyyy) _____

Part 3: Contribution Information

OPTION 1: Recurring Contributions

WARNING!!! Any new recurring contributions will supercede all current recurring contributions to your employer's 403(b) plan administered by OMNI. If you are currently contributing to multiple service providers under your employer's 403(b) plan, please be sure to list all contributions you wish to continue. Any active 403(b) contributions found in our records, but not listed below WILL BE DISCONTINUED. Also, a contribution may be discontinued by listing it below with an amount of zero.

Please withhold funds from my pay for the following 403(b) contributions until further notice:

Plan Type	Service Provider	Account #	Effective Date	Amount Per Pay	OR	Percent Per Pay Period
☐ 403(b) ☐ ROTH 403(b)						
☐ 403(b) ☐ ROTH 403(b)						
☐ 403(b) ☐ ROTH 403(b)						
☐ 403(b) ☐ ROTH 403(b)						
☐ 403(b) ☐ ROTH 403(b)						

If you have requested a percentage amount for any of the contributions above, please supply:
Your Annual Salary: _____ Number of Pay Periods Per Year: _____

☐ Please check here if you are NOT a full-time employee

OPTION 2: One-Time Contributions (Elective Contributions Only)

Plan Type	Service Provider	Account #	Effective Date	Amount	After this contribution, any 403(b) recurring contributions to this service provider should be:
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED
☐ 403(b) ☐ ROTH 403(b)					☐ DISCONTINUED ☐ RESUMED

☐ Please check here if you are NOT a full-time employee

OPTION 3: Participation Opt Out

☐ **I do not wish to participate at this time.** I understand that I may participate in the future simply by filling out a new Salary Reduction Agreement form.

Continued on next page...

Part 4: Agreements and Acknowledgements

The above named Employee where applicable, agrees as follows:

1. To modify his/her salary reduction as indicated above.
2. That his/her Employer transfers the above stated funds on Employee's behalf to OMNI for remittance to the selected Service Provider(s).
3. This SRA is legally binding and irrevocable with respect to amounts paid.
4. This SRA may be changed with respect to amounts not yet paid.
5. This SRA may be terminated at any time for amounts not yet paid or available, and that a termination request is permanent and remains in effect until a new SRA is submitted.
6. (a) That OMNI does not choose the annuity contract or custodial account in which your contributions are invested.
   (b) OMNI does not endorse any authorized Service Provider, nor is it responsible for any investments.
   (c) OMNI makes no representation regarding the advisability, appropriateness, or tax consequences of the purchase of the TSA and/or CA described herein.
   (d) (i) OMNI shall not have any liability whatsoever for any and all losses suffered by Employee with regard to his/her selection of the TSA and/or CA, its terms, the selection of any service provider, the financial condition, operation of or benefits provided by said service provider, or his/her selection and purchase of shares by any service provider. Nothing herein shall affect the terms of employment between Employer and Employee.
   (ii) Employee acknowledges that Employer has made no representation to Employee regarding the advisability, appropriateness, or tax consequences of the purchase of the annuity and/or custodial account described herein.
   (iii) The Employer shall not have any liability for any and all losses suffered by an Employee with regard to the selection(s) of any TSA and/or CA, any related terms and conditions, the selection of any service provider, the financial condition, operation of or benefits provided by any service provider or the selection and purchase of shares by any service provider.
7. To be responsible for setting up and signing the legal documents necessary to establish a TSA or CA.
8. To be responsible for naming a death beneficiary under their TSA or CA. This is normally done at the time the contract or account is established. Beneficiary designations should be reviewed periodically.
9. That some service providers may take administration fees from your 403(b) account.
10. When provided all required information in a timely manner, OMNI is responsible for determining that salary reductions do not exceed the allowable contribution limits under applicable law, and will complete MAC calculations as required by law.
11. To contact OMNI and complete the appropriate OMNI forms for any requests for distributions, loans, hardship withdrawals, account exchanges plan-to-plan transfers or rollover contributions. Processing fees for the foregoing transactions may apply.
12. This SRA is subject to the terms of the Services Agreement between OMNI and Employer, and to the Information Sharing Agreement between OMNI and the Service Providers.
13. This agreement supercedes all prior salary reduction agreements and shall automatically terminate if Employee's employment is terminated.

Part 5: Employee Signature (Mandatory)

I certify that I have read this complete agreement and that my requested salary reduction(s), if in excess of my base limit, represent(s) my wish to utilize any catch-up provisions for which I may be eligible. I further certify that I will notify OMNI in the event I begin contributing to another 403(b), 401(k) or 401(a) plan. I understand my responsibilities as an Employee under this Program, and I request that Employer take the action specified in this agreement. I understand that all rights under the TSA or CA established by me under the Plan are enforceable solely by my beneficiary, my authorized representative or me.

Employee Signature: _____ Date: _____

Part 6: Acknowledgement and Representation of Sales Agent/Representative (Not Required to Submit SRA)

I agree to comply with all pertinent written directives regarding the solicitation of Employee. In the event I provide OMNI with an Employee's date of birth ("DOB"), I acknowledge and agree that I must provide accurate information based on documentation provided to me by the Employee. Furthermore, I understand that any DOB information I provide to OMNI is utilized by OMNI to calculate the Employee's Maximum Allowable Contribution limits, which must be accurate to keep the Employer's plan in compliance with IRS regulations. All indemnification or other responsibility for a claim or demand arising from an error in employee DOB I provide will be governed by the Information Sharing Agreement between my employer and OMNI.

Sales Agent/Representative Name: _____ Phone: _____

Email: _____

Signature: _____ Date: _____

☐ I wish the above named agent to be copied on all e-mail communications sent to the plan participant, including certificate(s) of approval, which may be associated with this transaction.

Part 7: Employer Acknowledgement (If Applicable)

Salary: _____ # of TSA/CA Pay Periods: _____ Effective Payroll Date: _____

Employer Name & Title: _____

Employer Signature: _____ Date: _____

Please return this agreement to Omni Financial Group, Inc., unless otherwise advised by your employer:

Omni Financial Group, Inc.
220 Alexander Street, Suite 400 • Rochester, NY 14607
Toll Free: (877) 544-OMNI • Fax: (585) 672-6194
Please visit our website at **www.omni403b.com**

NORTH SALEM
Central School District

Duncan Wilson Ed. D.
Superintendent of Schools

Office of Business Administration

NEW YORK STATE DEFERRED COMPENSATION PLAN (NYSDCP)
457(b)
INFORMATION SHEET

The NYSDCP is a voluntary retirement savings plan governed by Section 457(b) of the United States Internal Revenue Code. The plan permits you to save for retirement without having your savings subject to current Federal or NY State income tax. Contributions and investment earnings accumulate on a tax-deferred basis until withdrawn. Investment options include Stable Income Fund, Money Markets and Mutual Funds.

Participation in this plan allows you to contribute additional dollars to a tax-deferred savings plan. For example, in 2024 an employee can contribute $23,000 to 403(b) and $23,000 to a 457(b) for a total of $46,000.

NSCSD deducts the amount you designate from your paycheck (pre-tax) and forwards it to the NYSDCP.

The IRS limits for 457(b) plans for 2024 are:

- Regular limit: $23,000.00
- Employees age 50 and older: $30,500.00
- Employees within 3 years of their maximum retirement benefit should contact NYSDCP to discuss eligibility for deferrals not made in prior years (Retirement Catch-up)

These limits change 1/1/2025

NSCSD acts merely as a collection agent.
Enrollment forms can be obtained at www.nysdcp.com

To start or make a change regarding your contribution, you must fill out the NYSDCP enrollment form and submit it to the NYSDCP address on the 2nd page of the application. It is important that a copy of your application be given to the NSCSD payroll department.

IMPORTANT INFORMATION

North Salem Central School District is not responsible for any investments.

New York State
Deferred Compensation Plan
A Plan for Your Future

New York State Deferred Compensation Plan
Enrollment Application

Internal Use Only - Account Executive #: _____ Click "**Enroll Now**" at www.nysdcp.com to enroll online

Personal Data

Name (please print): _____

Date of Birth: _____ SSN: _____ **Email*:** _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

County of your Employer: _____ Employer: _____

*Required - Please see eDelivery section for additional detail.

Employer Codes Your enrollment cannot be processed without this information.

Select only one option:

☐ **I am paid through the Office of the State Comptroller (OSC)**

New York State Employee ID Number (starts with N0): _____

State Agency ID Code (5 digit code on left side of paystub): _____

-OR-

☐ **I am paid through a local municipality (local town, village, or school)**

Local Plan ID: 0045420

If you are unaware of this number, please contact your Payroll Center or the HELPLINE

Deferral Information Prior to making your deferral selection, please read the following.

The minimum deferral allowed is 1% of your gross salary or $10 per pay period. **If you select 100%, your entire paycheck less any benefit withholdings will be deferred.**

If you are paid through the Office of the State Comptroller (OSC) – You must enter a percentage deferral. **(Whole percentage)**

If your employer is a local town, village, or school:

Check with your payroll department or the HELPLINE to determine **whether your employer accepts a deferral dollar amount or percentage.** Once determined provide a whole dollar or whole percentage amount below.

If your employer utilizes OMNI as a third-party payroll administrator, please contact OMNI to complete the enrollment deferral process. **Only your payroll department would be able to confirm if they use OMNI.**

Pre-Tax Deferral $_____ OR _____%

Roth Contributions $_____ OR _____%

Total $0 **OR** 0 **%*** *Total percentage cannot exceed 100%.

Beneficiary Designation

NOTE: Percentage split must total 100% for each category of beneficiary. If you designate a single primary or contingent beneficiary and do not list a percentage, it will be designated as 100%. A person **may not** be listed as both Primary and Contingent Beneficiary. If you select "Equal Percentage" for your beneficiaries, there may be some minor variance based upon the number of beneficiaries you have listed. For example, if you list three beneficiaries, the oldest beneficiary will be designated 33.34% and the other two will be 33.33%.

If additional space for beneficiaries is required, attach additional sheets and mark this box: ☐

Primary Beneficiary(ies) (must total 100%): ☐ **Equal Percentages for each Primary Beneficiary**

1. **Full Name:** _____ Allocation: _____%

   Relationship: _____ SSN: _____ Date of Birth: _____

2. **Full Name:** _____ Allocation: _____%

   Relationship: _____ SSN: _____ Date of Birth: _____

Contingent Beneficiary(ies) (must total 100%): ☐ **Equal Percentages for each Contingent Beneficiary**

1. **Full Name:** _____ Allocation: _____%

   Relationship: _____ SSN: _____ Date of Birth: _____

2. **Full Name:** _____ Allocation: _____%

   Relationship: _____ SSN: _____ Date of Birth: _____

eDelivery Opt Out

☐ **By checking this box,** I elect to receive my quarterly statements and other confirmations from the Plan by regular mail. I understand that by not checking this box, I elect eDelivery for quarterly statements, newsletters, investment performance reports and confirmations. With eDelivery, I will be emailed this information at the address provided under the Personal Data section when the information is posted to the Plan's Web site.

Deferral Allocation

Write the percentage you wish to allocate to each investment option. You may allocate your salary deferrals among any of the investment options listed below. The allocation of your contributions may be in any whole percentage and must total 100%.

DO IT FOR ME The following investment options are professionally managed asset allocation funds based on your expected retirement date:

_____% (1776) TRP Retirement Date 2010 Trust (CIT)
_____% (1777) TRP Retirement Date 2015 Trust (CIT)
_____% (1778) TRP Retirement Date 2020 Trust (CIT)
_____% (1779) TRP Retirement Date 2025 Trust (CIT)
_____% (1780) TRP Retirement Date 2030 Trust (CIT)
_____% (1781) TRP Retirement Date 2035 Trust (CIT)
_____% (1782) TRP Retirement Date 2040 Trust (CIT)
_____% (1783) TRP Retirement Date 2045 Trust (CIT)
_____% (1784) TRP Retirement Date 2050 Trust (CIT)
_____% (1785) TRP Retirement Date 2055 Trust (CIT)
_____% (1786) TRP Retirement Date 2060 Trust (CIT)
_____% (2884) TRP Retirement Date 2065 Trust (CIT)

DO IT YOURSELF The following core investment options permit participants to create their own asset allocation:

Stable income Fund

_____% (2756) NYSDCP Stable Income Fund

Bonds

_____% (1788) NYSDCB US Debt Index U/A (CIT)
_____% (1794) Voya Core Plus Trust Fund (CIT)

Balanced Funds

_____% (8957) Vanguard Wellington Fund - Admiral (MF)

Large Cap

_____% (1789) NYSDCB Equity Index U/A (CIT)
_____% (1787) Boston Partners Large-Cap Value Equity Fund (CIT)
_____% (1791) T. Rowe Price Equity Income Trust (CIT)
_____% (1792) T. Rowe Price Blue Chip Growth Trust (CIT)
_____% (2765) Vanguard PRIMECAP Fund - Admiral (MF)

Small Mid Cap

_____% (1790) NYSDCB Russell 2500 Index U/A (CIT)
_____% (653) Vanguard Strategic Equity Fund (MF)

Small Cap

_____% (1692) Delaware Small-Cap Value Fund CL I (MF)
_____% (1793) T. Rowe Price Integrated US Small-Cap Equity Fund CL I (MF)

International

_____% (2969) Fidelity Int'l Capital Appreciation (MF)
_____% (5025) NYSDCP Int'l Equity Active / (3006) Principal Diversified International (CIT)*
_____% (2082) Fidelity Global ex US Index Fund (MF)

Emerging Markets

_____% (1458) MSIF Emerging Markets Portfolio - Institutional (MF)

Speciality

_____% (1963) Pax Environmental Global Markets Fund - Institutional (MF)
_____% (1974) Fidelity OTC Fund - K Shares (MF)

_100_% Total for both columns must equal 100%

*Fund 5025 will be mapping to fund 3006 at a yet TBD date

Authorization

I agree to the terms of the New York State Deferred Compensation Plan. I authorize my employer to deduct the amount or percentage set forth herein until I provide further notice for the purposes of contributing it to my Plan account. I further authorize my employer to process any deferral changes I request through the Plan in the future. Deferrals made by participants who are not New York State residents may be subject to the state income tax in the year deferred in their state of residence. Please read your state income tax instructions carefully.

I have read and understand the terms contained in this form, including the attached Memorandum of Understanding, which is incorporated herein.

Signature: _____ **Date:** _____

Form Return

Mail:
New York State Deferred Compensation Plan
Administrative Service Agency
PO Box 182797
Columbus, OH 43218-2797

Overnight Mail:
New York State Deferred Compensation Plan
Administrative Service Agency, 1-LC-F2
1 Nationwide Plaza
Columbus, Ohio 43215-2239

Fax: 1-877-677-4329

When faxing paperwork, please allow two hours for your form to be received. If your fax is sent after 3:00pm your paperwork will be filed on the next business day.

Welcome to the New York State Deferred Compensation Plan. The Plan is a voluntary, long-term retirement savings program designed for your retirement needs. The amount you contribute to the Plan is deducted from your pay and any investment returns grow on a tax-deferred basis.

Contributions to the Plan:
The minimum contribution to the Plan is 1% of your gross pay (at least $10 per pay period). The maximum contribution you may make in 2024 is $23,000. If you are at least age 50 prior to the end of the current calendar year, you are eligible to contribute a maximum of $30,500. If you are within three years of the date that you are able to retire without a reduction in pension benefits, you may be eligible to make additional contributions. Contact an Account Executive or HELPLINE Representative at 1-800-422-8463 for more information and the forms to use the higher limits.

Pre-Tax Deferrals:
The amount you contribute to the Plan will be deducted from your pay on a pre-tax basis for federal and New York State income tax purposes, thereby reducing your taxable income for the calendar year. The investment returns also grow on a tax-deferred basis and income taxes are paid only when money is withdrawn from the Plan.

Roth Contributions:
These deductions are made from your pay on an after-tax basis. Contributions grow tax-deferred, but when money is distributed from the Plan, qualifying distributions are not subject to federal or New York State income taxes.

Processing Time Frame:
Enrollments are processed upon receipt; however, federal law states that deferrals may not begin before the start of the next calendar month, unless you make your election prior to your first day of service. You may change or cancel your deferral amount at any time, but these changes may also be subject to these timing limits.

Next Steps:
Please read the bullets below to understand the basics of the Plan and then complete your application

I understand that:

1. Withdrawals from the Plan may be taken only upon separation from employment, absence due to qualified military service, death, an unforeseeable financial emergency, attainment of age 59½, from an account that has been in inactive status for two years and has a balance of $5,000 or less (inclusive of any outstanding loan balance but exclusive of assets in a rollover account) or as a loan.
2. Participation in the Plan is not intended to replace a regular savings program necessary to cover day-to-day unanticipated financial expenses. Plan distributions for "Unforeseeable Financial Emergencies" are strictly regulated by federal laws. Should I need an unforeseeable emergency distribution, the request must be made in writing and detail the circumstances supporting the financial emergency. If my request is denied, I may appeal to the Review Committee.
3. I may enroll in the Plan for the purpose of transferring assets from another 457(b) deferred compensation plan, a 403(b), 401(k), 401(a), Keogh plan, a traditional or rollover IRA without becoming an active participant.
4. Unless I have opted for a paper statement, I will receive an email notification when my quarterly statement, Quarterly newsletter and investment performance report are available on the Website. Please call the HELPLINE promptly with any changes.
5. If my employer has opted to allow Roth contributions, contributions to the Roth account may not be reclassified after made. The investment allocation for Roth contributions will be the same as for any pre-tax deferrals. Distributions of Roth contributions must meet the same withdrawal requirements as pre-tax withdrawals.
6. There is an administrative fee deducted from my Plan account on a semi-annual basis as outlined in the Plan's Investment Options Guide. These fees are subject to change.

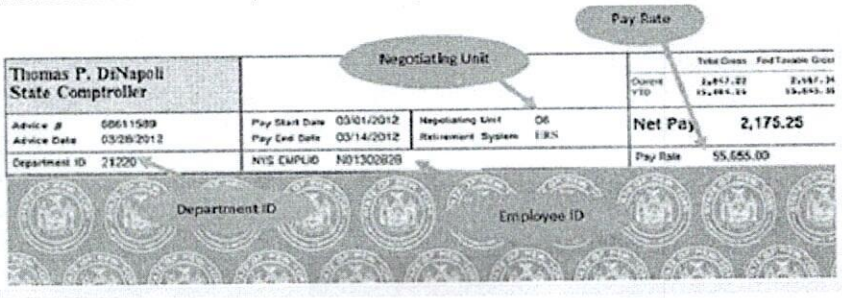
Information relating to the Plan or a copy of the Plan Document may be obtained by calling the HELPLINE at 1-800-422-8463 or visiting the Plan's Web site at www.nysdcp.com.

Tips for Completing the Application

<u>State Employees</u>

If you are employed by a State Agency, please see the screen shot below to assist you with identifying the information necessary to complete the application.

This application will require you to include your five-digit Department ID, which is located on the upper left corner of your pay stub, and your NYS Employee ID that is listed next to the Department ID. If you do not have this information, your application cannot be processed.



Local Employees

If you are employed by a city, town, or library system that contains its own payroll department, the application requires your Local Plan ID. This six-digit number can be obtained by contacting your payroll department or our HELPLINE at 1-800-422-8463.

Deferral Information

State Employees

When entering your deferral amount, you must provide a percentage of your gross pay. This percentage must be a whole number. If you need assistance calculating a percentage for your deferral, please contact our HELPLINE at 1-800-422-8463.

Local Employees

Before completing your application, please check with your employer or our HELPLINE to find out if your employer requires deferrals to be entered as a dollar amount or as a percentage.

Please note that if you elect a deferral rate of 100%, you are authorizing the Plan to deduct the remaining balance of your paycheck after all other required pre-tax deductions have been taken. If you are electing this deferral percentage for a lump sum payment to the Plan, it is important to contact the HELPLINE with the exact date of the lump sum payment.

Office of the New York State Comptroller

NYSLRS

New York State and Local Retirement System

110 State Street, Albany, New York 12244-0001

Please type or print clearly in blue or black ink

Received Date

Designation of Beneficiary with Contingent Beneficiaries

RS 5127
(Rev. 11/22)

NYSLRS ID

Social Security Number [last 4 digits]

XXX-XX-

Retirement System [check one]

Employees' Retirement System (ERS) ☐

Police and Fire' Retirement System (PFRS) ☐

THIS FORM MUST BE SIGNED, NOTARIZED AND FILED WITH THE RETIREMENT SYSTEM PRIOR TO YOUR DEATH TO BE EFFECTIVE.

Member / Pensioner Information

Name:_____ Former Name: (if applicable) _____

Home Address: _____

City, State, Zip Code:_____

Phone Number:_____ Email Address:_____

Employed by:_____ Employer Address:_____

IMPORTANT INFORMATION REGARDING THIS FORM

- If you find this form is not suited to the type of designation you prefer please advise the Retirement System. In the meantime, for your protection and the protection of your beneficiary(ies), you should make an interim designation using this form. If you wish to designate more beneficiaries than this form allows or to designate a Trust, Guardian-ship or payment under the Uniform Transfers to Minors Act please contact the Retirement System for the appropriate form.
- Attachments to your beneficiary form are **unacceptable**.
- New beneficiary forms filed will supersede any previous designation. Therefore, if you want to **add** or **delete** a beneficiary, for example a new child, you must include on the new form all beneficiaries you wish to designate.
- The same person or persons cannot be designated as both primary and contingent beneficiaries. We can make payment to a contingent beneficiary(ies) only if all primary beneficiary(ies) die before you do.
- If you wish to have these benefits distributed through your estate, you should name "my estate" as beneficiary. Your estate can be named as either primary or contingent beneficiary. However, if you name your estate as primary beneficiary, you may not name any contingent beneficiary.
- This form is for designating beneficiaries to receive your ordinary death or post retirement death benefit. You may not designate beneficiaries to receive accidental death benefits. The beneficiaries entitled to receive accidental death benefits are mandated by statute.

Make sure that you:

- **Complete all required information.**
- **Sign and date the form.**
- **Have the form notarized, making sure the notary has entered their expiration date.**
- **Mail your completed form to:**

  New York State and Local Retirement System
  110 State Street
  Albany, NY 12244-0001

PERSONAL PRIVACY PROTECTION LAW

In accordance with the Personal Privacy Law you are hereby advised that pursuant to the Retirement and Social Security Law, the Retirement System is required to maintain records. The records are necessary to determine eligibility for and to calculate benefits. Failure to provide in-formation may result in the failure to pay benefits the way you prefer. The System may provide certain information to participating employers. The official responsible for maintaining these records is the Director of Member & Employer Services, New York State and Local Retirement Systems, Albany, NY 12244. For questions concerning this form, please call 1-866-805-0990 or 518-474-7736.

SOCIAL SECURITY DISCLOSURE REQUIREMENT

In accordance with the Federal Privacy Act of 1974, you are hereby advised that disclosure of the Social Security Account Number is mandatory pursuant to sections 11, 31, 34 and 334 of the Retirement and Social Security Law. The number will be used in identifying retirement records and in the administration of the Retirement System.

Please go to the reverse side of this form to designate beneficiaries, sign and date the form and have the form notarized.

Do not alter this form or make stipulations. The use of correction fluid or other alterations on this form will render the designation invalid.

To the Comptroller of the State of New York:

Designation of Primary Beneficiary(ies). I hereby name the following beneficiary(ies) to receive any ordinary death or post retirement death benefit payable on my behalf. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. I reserve the right to change the designation at any time.

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Designation of Contingent Beneficiary(ies). If all of the designated primary beneficiaries die before I do, any ordinary death or post retirement death benefit payable on my behalf shall be paid to the following. If I have named more than one beneficiary, it is my intention that those living at the time of my death should share equally any benefit payable. If I out-live these beneficiaries, any benefit payable should be paid to my estate or any other beneficiary I name thereafter. I reserve the right to change this designation at any time.

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

Name _____
Address _____
_____
Relationship _____ Birth Date _____
Phone Number _____

This form must be signed, dated and notarized in order to be valid.

I certify that the information on my application is true and complete to the best of my knowledge. I further certify that I am aware that any false statement I knowingly make or permit to be made on this or any record of the Retirement System constitutes a crime punishable by potential incarceration and other sanctions.

Member / Pensioner Signature _____ Date _____

ACKNOWLEDGEMENT TO BE COMPLETED BY A NOTARY PUBLIC

State of _____ County of _____ On the _____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

_____
NOTARY PUBLIC (Please sign and affix stamp)

NET-11.4 (12/22)

NEW YORK STATE TEACHERS' RETIREMENT SYSTEM
10 Corporate Woods Drive, Albany, NY 12211-2395

OFFICE SERVICES ONLY

DESIGNATION OF BENEFICIARY FOR IN-SERVICE OR POST-RETIREMENT PARAGRAPH 2 DEATH BENEFIT

EmplID ______ Last 4 Digits of Member's Social Security # ______

Last Name	First Name	M.I.
Street		
City, State, Zip		
Email Address	Phone Number	

I, the undersigned, revoking all former designations made by me pursuant to my death benefit coverage, hereby direct NYSTRS, in the event of my death, to pay the death benefit allowable on my account and the total of my contributions, if any, in one lump sum payment to the beneficiary or beneficiaries named below. Should I survive all named beneficiaries, any death benefit payable shall be paid to my estate.

Primary Beneficiaries — If more than one primary beneficiary is named, the share of any beneficiary who dies before me shall be divided equally among the surviving primary beneficiaries.

Contingent Beneficiaries — Should I survive my primary beneficiary or beneficiaries, any benefit payable at my death shall be paid in equal shares, unless otherwise indicated, to the surviving contingent beneficiary or beneficiaries.

BENEFICIARY INFORMATION

Name	Relationship		
Street	Date of Birth ***OR*** Date of Will/Trust	*Check One* Primary ☐ Contingent ☐	*Check One* Male ☐ Female ☐ Other ☐
City, State, Zip	Beneficiary's Social Security #/Tax ID		
Name	Relationship		
Street	Date of Birth ***OR*** Date of Will/Trust	*Check One* Primary ☐ Contingent ☐	*Check One* Male ☐ Female ☐ Other ☐
City, State, Zip	Beneficiary's Social Security #/Tax ID		
Name	Relationship		
Street	Date of Birth ***OR*** Date of Will/Trust	*Check One* Primary ☐ Contingent ☐	*Check One* Male ☐ Female ☐ Other ☐
City, State, Zip	Beneficiary's Social Security #/Tax ID		
Name	Relationship		
Street	Date of Birth ***OR*** Date of Will/Trust	*Check One* Primary ☐ Contingent ☐	*Check One* Male ☐ Female ☐ Other ☐
City, State, Zip	Beneficiary's Social Security #/Tax ID		

***** This form must be signed and acknowledged before a Notary Public in order to be valid *****

Signature of Member

State of ____________________, County of ____________________________ On this ______ day of ________________, 20____

before me personally appeared ____,
(Print Applicant's Name)

personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to the within instrument, and acknowledged to me that they executed the same in their capacity, and that by their signature on the instrument, the individual, or the person upon behalf of which the individual acted, executed the instrument.

Printed Name of Notary: ______________________________

Signature of Notary: ______________________________ ______________________ **Affix Stamp *(include expiration date)***

Please review the information on the reverse before mailing.

INSTRUCTIONS FOR DESIGNATING A BENEFICIARY

1. Please type or print in black or blue ink. ***This form must be properly notarized.*** You may wish to contact the IRS or your tax advisor to determine the tax impact of any beneficiary designation.
2. **Any number of primary and contingent beneficiaries may be named, but you must designate at least one primary beneficiary.** The same person or persons cannot be designated as both primary and contingent beneficiaries. The System will make payment to a contingent beneficiary(ies) only if all primary beneficiaries die before you do. If you survive all of the primary and contingent beneficiaries named, the System will pay your estate.
3. **Any alterations to this form must be initialed.** Stipulations (e.g. "per stirpes") or attachments to your designation are **not acceptable**.
4. **If you desire more beneficiaries than can fit on one form, you must use an additional designation form, each clearly marked as "form 1 of 2" and "form 2 of 2," etc. Each form must be signed, notarized and submitted at the same time.** Additional forms can be downloaded from our website at NYSTRS.org.
5. **New beneficiary forms filed will supersede any previous designation.** If you want to add a beneficiary, for example a new child, you must file a new form that includes all beneficiaries you wish to designate.
6. **If you designate persons:**
   - List full legal names (e.g. Mary Smith). Unborn children may not be named.
   - Provide complete information requested for each beneficiary, including whether they are primary or contingent.
   - List each beneficiary separately by their full legal name.
   - ***Do not*** **number your beneficiaries. Numbering of beneficiaries will result in an invalid designation.**
7. **If you designate your estate:**
   - Use the words "My Estate" on the beneficiary name line. No other information is needed.
   - If your estate is named as primary beneficiary, do not name a contingent beneficiary. A contingent beneficiary would only be entitled to a benefit if the primary beneficiary ceases to exist before the member's death.
8. **If you designate a corporation** (charitable, civic, religious, educational or health-related organization, not a personal business), please be sure to use the exact name of the corporation. No other information is needed on this form; however, a copy of the certification of corporation is required. If a religious organization is listed, the System requires a certificate of incorporation or a charter.
9. **If you designate the Trustee of an Inter Vivos Trust:**
   - The Trust must be a valid trust under state law.
   - Complete the beneficiary information as follows:
     - Name & address - Name and address of current Trustee (this may be the member)
     - Date of Birth - Date of original Trust
     - Beneficiary SSN - Tax ID of Trust (may be member's Social Security #)
     - Relationship - "Trustee of [Name of Trust]"
   - You must provide a complete copy of the Trust or a Certification of Trust. A Certification of Trust (LEG-1) is available at NYSTRS.org.
10. **If you designate the Trustee of a Testamentary Trust:**
    - The Will under which the Trust is established must be your own Will.
    - Complete the beneficiary information as follows:
      - Name & address - Name and address of the Trustee to be appointed
      - Date of Birth - Date of Will
      - Beneficiary SSN - leave blank
      - Relationship - "Trustee of the Testamentary Trust under [Article/Paragraph #] of my Will"
11. **If you designate a Custodian for a minor under the Uniform Transfer to Minors Act (UTMA):**
    - You must designate each minor separately, even if the Custodian is the same individual.
    - Complete the beneficiary information as follows:
      - Name & address - Custodian to be appointed
      - Date of Birth - Date of Birth of Minor
      - Beneficiary SSN - SSN of Minor
      - Relationship - "As Custodian for [Minor's name] under the UTMA"
12. **If you have a Certified Domestic Relations Order (DRO) on file with the System** requiring you to designate your ex-spouse as beneficiary of any death benefit, please list your ex-spouse as a primary beneficiary and write "per DRO" next to his/her name, then list any other primary or contingent beneficiary(ies) you wish to receive the remaining benefit.

BENEFICIARY DESIGNATION CHECKLIST

- ☐ Is your designation form **signed** *and* **notarized**?
- ☐ Did you write the last four digits of your Social Security number in the appropriate boxes on the reverse?
- ☐ Did you designate at least one primary beneficiary?
- ☐ Did you initial any alterations you may have made?
- ☐ If you indicated percentages for your primary or contingent beneficiaries, do the percentages equal 100%?

IN ORDER FOR YOUR NEW DESIGNATION TO BE EFFECTIVE, IT MUST BE PROPERLY COMPLETED, SIGNED, NOTARIZED AND RECEIVED BY THE SYSTEM PRIOR TO YOUR DEATH.

IF YOU HAVE ANY QUESTIONS WHEN COMPLETING TH... FORM, PLEASE CALL THE SYSTEM AT (800) 348-7298, Ext. 4130

LIFE INSURANCE

J.J. STANIS AND COMPANY, INC 377 OAK STREET, SUITE 406 GARDEN CITY, NY 11530
PHONE: (516) 465-3900 FAX#: (516) 465-3920 WEBSITE: WWW.JJSTANISCO.COM

ENROLLMENT AND CHANGE FORM

NORTH SALEM CSD

Type of Coverage:	☐ Group Term Life Insurance/AD&D				Unit: ☐ Administrator ☐ Bus Drivers ☐ SRP ☐ All Others (complete job title)
☐ New Hire	☐ Late Enrollee	☐ Rehire			
☐ Change Beneficiary Change in Section B	☐ New Address Change is Section A	☐ Name Change, previous Name:			

A. Employee Information

*Name (Last, First)			*Gender ☐ M ☐ F *Date of Birth:
*Street Address			*Date of F/T Hire
*City	*State	*Zip	*Hours worked per week
*Social Security No.			*Annual Salary $
*Job Title			Work Phone
Email Address (personal or work)			

* indicates a required field

B. Beneficiaries for Life and AD&D

☐ Add Beneficiary ☐ Change existing beneficiary to individual(s) below: (if more space is needed, attach extra copies.)

Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship
Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay:			
Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship

If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

C. Participation/Waiver

☐ **Request to Participate:** I hereby request the policyholder to arrange the issuance of group insurance to which I am entitled, or to which I may be entitled, and I authorize my employer to make the periodic deductions from my earnings as my contributions toward the cost of insurance, if applicable.

☐ **Waiver of Insurance:** I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required to participate in the plan at a later date.

Reason for refusing: ☐ Not Interested ☐ Other, please specify:

The information provided above is true and complete to the best of my knowledge and belief.

Employee Signature:_____ **Date:**_____

Employer Representative: _____ **Date:** _____

(08/2019)

Do Not Write Below This Line (For J. J. Stanis and Company, Inc. Only)

NORTH SALEM
Central School District

Duncan A. Wilson, Ed. D.
Superintendent of Schools

Barbara Briganti
Interim Assistant Superintendent
for Business Administration

To: Administrators
CSEA Unit Members
Custodial/Maintenance Personnel
Twelve-Month Transportation Personnel

From: Barbara Briganti
Interim Assistant Superintendent
for Business Administration

Date: April 22, 2024

Subject: **Holiday Schedule 2024-2025**

Independence Day	Thursday	July 4, 2024
Labor Day	Monday	September 2, 2024
Columbus Day/ Indigenous People's Day	Monday	October 14, 2024
Veteran's Day	Monday	November 11, 2024
Thanksgiving Recess	Thursday Friday	November 28, 2024 November 29, 2024
Holiday Recess	Tuesday Wednesday (Christmas Day) Tuesday	December 24, 2024 December 25, 2024 December 31, 2024
	Wednesday (New Year's Day)	January 1, 2025
Dr. Martin Luther King Jr.	Monday	January 20, 2025
President's Day	Monday	February 17, 2025
Good Friday	Friday	April 18, 2025
Memorial Day	Monday	May 26, 2025
Juneteenth	Thursday	June 19, 2025