Clear form

Please use Acrobat Reader to complete this document.

Save form

Print ALL pages

Print required and optional pages, NO instructions

Philip G. Kiko
Chief Administrative Officer

Office of the
Chief Administrative Officer
U.S. House of Representatives
Washington, DC 20515-6860

U.S. House of Representatives Employee On-Boarding

This cover page is intended to facilitate the online completion of these forms using Adobe Reader. The personal information typed on this page will populate into corresponding fields on each applicable page. *We strongly recommend using Adobe Reader to complete the forms because it will save you time and effort* and provide the option to print only the pages required to receive a paycheck and benefits or the entire packet with instructions.

Pages 6-7, 9, 14, 17, 19, 21-22, along with 32-33 are required for a complete Appointment package. Pages 18, 25-28 are benefit forms that do not need to be completed on the date of hire but will require action by the employee by a certain deadline (see page 23).

Name

First Middle Last

Social Security Number — Please enter SSN in format: NNN-NN-NNNN.

Date of Birth — Enter DATE in format: MM/DD/YYYY

Address Line 1

Address Line 2

City State Select your state Zipcode

Home Phone Number

Daytime Phone Number

Office Phone Number

Enter PHONE Numbers in format: 0123456789

Employing Office Name

Effective Date of Appointment

Today's Date

Enter DATES using format: MM/DD/YYYY

A Payroll Authorization Form (PAF), signed by the Member or Chairman, must accompany this packet. The PAF Smartform may be found on:

HouseNet >Forms >Payroll Authorization Form (Smart Form).

Please remember to sign ALL forms!

Revised 04/11/2018

Welcome TO THE HOUSE

We hope this reference guide from the Office of the Chief Administrative Officer (CAO) helps you to find the services you need.

Got questions? Need answers?

If you don't know where to turn or who to call, search HouseNet or contact First Call. First Call staffers will be able to find an answer to any of your questions. First Call also provides passport services and room scheduling for conferences and meetings. Contact First Call at **202-225-8000**.

Need Technical or Cybersecurity Help?

Contact the Technology Service Desk (TSD) at **202-225-6002**. Technical assistance is available 24/7. Also, call the TSD if you have any concerns about email phishing attacks or hacking attempts.

Payroll and Benefits

For questions about your paycheck or health and benefits coverage, call **202-225-1435** or visit us in person at B-215 Longworth.

Counseling

Call the Office of Employee Assistance at **202-225-4000** for help with personal, emotional, behavioral, substance abuse, and stress-related difficulties. Counseling is free and confidential.

Education

Contact the House Learning Center at **202-226-3800** or online at **registerme.house.gov** for free classes to help you do your job.

Food Services

There are three cafeterias, a Dunkin' Donuts and a Subway shop in House Office Buildings in addition to vending areas and snack and beverage markets. Check HouseNet for menus and locations.

Personal Services

The House Campus hosts many personal services such as a fitness center, barbershop, dry cleaner, child care, and more. Information about each can be found on HouseNet under the Campus tab.

Office Supply and Gifts

Supplies for your office or gifts for friends can be found in the Office Supply Store and Gift Shop. They are located next to each other in B-217 & B-218 Longworth.

HouseNet

The intranet for staffers

HouseNet.house.gov

Social Media

Stay up to date, follow the CAO

Twitter.com/CAOHouse

Facebook.com/CAOHouseofReps

Instagram.com/ushousephoto

Important Phone Numbers

First Call
202-225-8000

Technology Service Desk
202-225-6002

Payroll and Benefits
202-225-1435

Office of Employee Assistance
202-225-4000

House Learning Center
202-226-3800

House Alert

Sign up for the emergency communication system

alert.house.gov

Workplace Rights and Responsibilities Education

House Resolution 630, requires each Member, Officer, and employee (including staff, paid and unpaid interns, fellows, and detailees) of the House of Representatives to complete an in-person education program focused on workplace rights and responsibilities.

- This annual session must be completed within 90 days of House employment. You may register using your House email via https://registerme.house.gov.

For more information or questions regarding the Workplace Rights and Responsibilities education requirement, please contact the Workplace Rights Hotline by calling (202) 225-9500 or emailing WorkplaceRights@mail.house.gov.

Ethics Training

The Committee on Ethics is responsible for providing annual ethics training to all House Members, Officers, and employees.

New Employees

- All new employees must complete the annual training within the first 60 days of House employment.
- New employees who work in the Capitol Hill offices must attend a live ethics training briefing. View https://ethics.house.gov/legislation/schedule/new-employee. You may register through https://registerme.house.gov/public/course/browse using your House email.
- New employees in the district may complete online training via https://houseconnect.house.gov, using their Active Directory credentials (House Account login).

Senior Staff*

- New senior staff must complete new employee ethics training within 60 days of beginning House employment (see above) and complete a second hour of specialized "senior staff" training before the end of the current Congress.
- There are two options for fulfilling the specialized "senior staff" training requirement:
    1. Watch the *Senior Staff* or the *Periodic Transaction Report* training videos available on https://houseconnect.house.gov; or
    2. Attend a live *Senior Staff*, or *Financial Disclosure*, or *Periodic Transaction Report* training session. Visit https://ethics.house.gov/legislation/schedule/senior-staff.

* The definition of "senior staff" may be found here: https://ethics.house.gov/legislation/schedule/senior-staff.

Information Security Awareness Training

House policy requires that all individuals who have access to the House network complete information security awareness training once a year.

- You must complete the annual training within 30 days from issuance of Active Directory credentials (House Account login). To complete the training, visit https://housenet.house.gov/for-staff/responsibilities/information-security-awareness-training where you will find instructions and a secure link to the external training website.

For questions, please contact informationsecurityawarenesstraining@mail.house.gov or call 202-226-1513.

Instructions for Employment Eligibility Requirements and Form I-9 Employment Eligibility Verification

- **Note**: The Employment Eligibility requirement is a separate and additional requirement from the Form I-9 Employment Eligibility Verification (DHS & USCIS) and documentation requirements. Both 1 & 2 **MUST** be fulfilled for a complete Appointment package.

1. **Employment Eligibility Requirements: Required with all new hire Appointment packages**

- **U.S. Citizen** – The Employment Eligibility process requires that a prospective employee provide one of the documents listed in the Employment Eligibility Requirements with their completed Appointment package to prove the prospective employee is a U.S. Citizen.
- **Non - U.S. Citizen** – The Employment Eligibility process requires that a prospective Non-U.S. Citizen employee provide one of the documents listed in the Employment Eligibility Requirements with a completed Appointment package to meet employment eligibility requirements.
    - Questions on Non-U.S. Citizen requirements or notarized affidavits should be directed to the Office of General Counsel at 202-225-9700.

2. **Form I-9 Employment Eligibility Verification (DHS & USCIS): Required with all new hire Appointment packages**

- Form I-9 is to be completed by prospective employee and certified by employing office:
    - Section 1 completed by employee, sections 2 and 3 to be completed by your employing office.
    - If a List A document is used on prospective employee's Form I-9, a color copy of the document must be submitted with the Form I-9 to meet photo matching requirements.
- Effective 05-16-2014, the CAO Office of Payroll & Benefits will run new hire's completed Form I-9 through the Department of Homeland Security's E-Verify System to verify employment eligibility in the United States for all new hires. Offices will no longer have the option to use the Department of Homeland Security's E-Verify System themselves.
- Effective 05-16-2014, Completed Appointment packages must be submitted to the Office of Payroll & Benefits **two business days prior** to effective date of hire.

Documents for Employment Eligibility Verification Requirements

United States Citizens

Provide proof of the prospective employee's United States Citizenship via either:

a. a photocopy of an original or certified copy of birth certificate bearing an official seal; ***or***

b. a color copy of United States Passport or Passport Card; **or**

c. a photocopy of naturalization certificate; **or**

d. a photocopy of a certificate of citizenship.

Non-U.S. Citizens

Provide a signed, notarized affidavit by the prospective employee attesting that he/she satisfies any ***one*** of the following categories:

e. The prospective employee is a lawfully admitted permanent resident ***and*** is seeking citizenship within the timing requirements of 8 U.S.C. § 1324b(a)(3)(B). Under this option, a prospective employee must attach to the affidavit proof of lawful permanent residency;

f. The prospective employee has been admitted as a refugee under 8 U.S.C. § 1157, and has filed a declaration of intention to become a lawful permanent resident and then a citizen when eligible. Under this option, a prospective employee must attach to the affidavit proof of admission as a refugee;

g. The prospective employee has been granted asylum under 8 U.S.C. § 1158, and intends to become a lawful permanent resident and then a citizen when eligible. Under this option, a prospective employee must attach to the affidavit proof of the grant of asylum; or

h. The prospective employee is a person who owes allegiance to the United States. A person who owes allegiance to the United States is generally defined as one who is a national of American Samoa, the Swains Island, or the Northern Mariana Islands, and nationals who meet other requirements described in 8 U.S.C. §1408.

Form I-9 Instructions

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶**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
			Select y	

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)*
This document requires a Wet signature.	

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)*
This document requires a Wet signature.	

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

SKIP THIS SECTION

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)***

U.S. House of Representatives

B215 Longworth House Office Building **Washington** **DC** **20515**

SKIP THIS SECTION

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Form I-9 Instructions

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:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		
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				

Examples of many of these documents appear in Part 13 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

U.S. HOUSE OF REPRESENTATIVES
NEW HIRE HEALTH DESIGNATION FORM

NOTE: This form is to be signed by the Employing Authority and submitted with the appointment payroll authorization form (PAF) to designate an Employee's health care eligibility. Therefore, if this form is not turned in with the PAFs, the Employing Authority is delegating their authority to the Chief Administrative Office to determine health care eligibility.

FROM: _____
(Employing Office)

TO: THE CHIEF ADMINISTRATIVE OFFICER OF THE HOUSE

I have determined that the below employee, whom I hired on _____,

☐ **DOES** meet the definition of "congressional staff" in **5 C.F.R. § 890.101. (DC Health Link)**

☐ **DOES NOT** meet the definition of "congressional staff" in **5 C.F.R. § 890.101. (FEHBP)**

SOCIAL SECURITY NUMBER (Employee Number if current employee)	**LAST NAME**	**FIRST NAME**

OR

☐ I delegate my authority to the Chief Administrative Officer to determine whether _____, whom I hired on _____, meets the definition of "congressional staff" in 5 C.F.R. § 890.101. I understand that the Chief Administrative Officer will designate the individual as "congressional staff" if they are paid exclusively from the MRA(s).

This document requires a Wet signature.

_____
(Date)

_____
(Signature of Employing Authority)

_____
(Type or print name of Employing Authority)

Form W-4 (2018)

Future developments. For the latest information about any future developments related to Form W-4, such as legislation enacted after it was published, go to *www.irs.gov/FormW4*.

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. You may claim exemption from withholding for 2018 if **both** of the following apply.

- For 2017 you had a right to a refund of **all** federal income tax withheld because you had **no** tax liability, **and**
- For 2018 you expect a refund of **all** federal income tax withheld because you expect to have **no** tax liability.

If you're exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2018 expires February 15, 2019. See Pub. 505, Tax Withholding and Estimated Tax, to learn more about whether you qualify for exemption from withholding.

General Instructions

If you aren't exempt, follow the rest of these instructions to determine the number of withholding allowances you should claim for withholding for 2018 and any additional amount of tax to have withheld. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

You can also use the calculator at ***www.irs.gov/W4App*** to determine your tax withholding more accurately. Consider using this calculator if you have a more complicated tax situation, such as if you have a working spouse, more than one job, or a large amount of nonwage income outside of your job. After your Form W-4 takes effect, you can also use this calculator to see how the amount of tax you're having withheld compares to your projected total tax for 2018. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Note that if you have too much tax withheld, you will receive a refund when you file your tax return. If you have too little tax withheld, you will owe tax when you file your tax return, and you might owe a penalty.

Filers with multiple jobs or working spouses. If you have more than one job at a time, or if you're married and your spouse is also working, read all of the instructions including the instructions for the Two-Earners/Multiple Jobs Worksheet before beginning.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you might owe additional tax. Or, you can use the Deductions, Adjustments, and Other Income Worksheet on page 3 or the calculator at *www.irs.gov/W4App* to make sure you have enough tax withheld from your paycheck. If you have pension or annuity income, see Pub. 505 or use the calculator at *www.irs.gov/W4App* to find out if you should adjust your withholding on Form W-4 or W-4P.

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

Specific Instructions

Personal Allowances Worksheet

Complete this worksheet on page 3 first to determine the number of withholding allowances to claim.

Line C. ***Head of household please note:*** Generally, you can claim head of household filing status on your tax return only if you're unmarried and pay more than 50% of the costs of keeping up a home for yourself and a qualifying individual. See Pub. 501 for more information about filing status.

Line E. Child tax credit. When you file your tax return, you might be eligible to claim a credit for each of your qualifying children. To qualify, the child must be under age 17 as of December 31 and must be your dependent who lives with you for more than half the year. To learn more about this credit, see Pub. 972, Child Tax Credit. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line E of the worksheet. On the worksheet you will be asked about your total income. For this purpose, total income includes all of your wages and other income, including income earned by a spouse, during the year.

Line F. Credit for other dependents. When you file your tax return, you might be eligible to claim a credit for each of your dependents that don't qualify for the child tax credit, such as any dependent children age 17 and older. To learn more about this credit, see Pub. 505. To reduce the tax withheld from your pay by taking this credit into account, follow the instructions on line F of the worksheet. On the worksheet, you will be asked about your total income. For this purpose, total income includes all of

Separate here and give Form W-4 to your employer. Keep the worksheet(s) for your records.

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▸ **Whether you're entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074
2018

1 Your first name and middle initial	Last name	2 Your social security number

Home address (number and street or rural route)

3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note: If married filing separately, check "Married, but withhold at higher Single rate."

City or town, state, and ZIP code
, Select your state,

4 If your last name differs from that shown on your social security card, check here. You must call 800-772-1213 for a replacement card. ▸ ☐

5	Total number of allowances you're claiming (from the applicable worksheet on the following pages) . . .	5	
6	Additional amount, if any, you want withheld from each paycheck	6	$
7	I claim exemption from withholding for 2018, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here . . . . . ▸	7	

This form is only used to estimate the Federal taxes that you wish to have deducted from your paycheck. Do NOT submit this form. Please enter the results of your calculations on the form on the Substitute W-4 provided with this packet.

your wages and other income, including income earned by a spouse, during the year.

Line G. Other credits. You might be able to reduce the tax withheld from your paycheck if you expect to claim other tax credits, such as the earned income tax credit and tax credits for education and child care expenses. If you do so, your paycheck will be larger but the amount of any refund that you receive when you file your tax return will be smaller. Follow the instructions for Worksheet 1-6 in Pub. 505 if you want to reduce your withholding to take these credits into account.

Deductions, Adjustments, and Additional Income Worksheet

Complete this worksheet to determine if you're able to reduce the tax withheld from your paycheck to account for your itemized deductions and other adjustments to income such as IRA contributions. If you do so, your refund at the end of the year will be smaller, but your paycheck will be larger. You're not required to complete this worksheet or reduce your withholding if you don't wish to do so.

You can also use this worksheet to figure out how much to increase the tax withheld from your paycheck if you have a large amount of nonwage income, such as interest or dividends.

Another option is to take these items into account and make your withholding more accurate by using the calculator at *www.irs.gov/W4App*. If you use the calculator, you don't need to complete any of the worksheets for Form W-4.

Two-Earners/Multiple Jobs Worksheet

Complete this worksheet if you have more than one job at a time or are married filing jointly and have a working spouse. If you don't complete this worksheet, you might have too little tax withheld. If so, you will owe tax when you file your tax return and might be subject to a penalty.

Figure the total number of allowances you're entitled to claim and any additional amount of tax to withhold on all jobs using worksheets from only one Form W-4. Claim all allowances on the W-4 that you or your spouse file for the highest paying job in your family and claim zero allowances on Forms W-4 filed for all other jobs. For example, if you earn $60,000 per year and your spouse earns $20,000, you should complete the worksheets to determine what to enter on lines 5 and 6 of your Form W-4, and your spouse should enter zero ("-0-") on lines 5 and 6 of his or her Form W-4. See Pub. 505 for details.

Another option is to use the calculator at *www.irs.gov/W4App* to make your withholding more accurate.

Tip: If you have a working spouse and your incomes are similar, you can check the "Married, but withhold at higher Single rate" box instead of using this worksheet. If you choose this option, then each spouse should fill out the Personal Allowances Worksheet and check the "Married, but withhold at higher Single rate" box on Form W-4, but only one spouse should claim any allowances for credits or fill out the Deductions, Adjustments, and Additional Income Worksheet.

Instructions for Employer

Employees, do not complete box 8, 9, or 10. Your employer will complete these boxes if necessary.

New hire reporting. Employers are required by law to report new employees to a designated State Directory of New Hires. Employers may use Form W-4, boxes 8, 9, and 10 to comply with the new hire reporting requirement for a newly hired employee. A newly hired employee is an employee who hasn't previously been employed by the employer, or who was previously employed by the employer but has been separated from such prior employment for at least 60 consecutive days. Employers should contact the appropriate State Directory of New Hires to find out how to submit a copy of the completed Form W-4. For information and links to each designated State Directory of New Hires (including for U.S. territories), go to ***www.acf.hhs.gov/programs/css/employers***.

If an employer is sending a copy of Form W-4 to a designated State Directory of New Hires to comply with the new hire reporting requirement for a newly hired employee, complete boxes 8, 9, and 10 as follows.

Box 8. Enter the employer's name and address. If the employer is sending a copy of this form to a State Directory of New Hires, enter the address where child support agencies should send income withholding orders.

Box 9. If the employer is sending a copy of this form to a State Directory of New Hires, enter the employee's first date of employment, which is the date services for payment were first performed by the employee. If the employer rehired the employee after the employee had been separated from the employer's service for at least 60 days, enter the rehire date.

Box 10. Enter the employer's employer identification number (EIN).

This form is only used to estimate the Federal taxes that you wish to have deducted from your paycheck. Do NOT submit this form. Please enter the results of your calculations on the form on the Substitute W-4 provided with this packet.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for yourself	**A**
B	Enter "1" if you will file as married filing jointly	**B**
C	Enter "1" if you will file as head of household	**C**
D	Enter "1" if: • You're single, or married filing separately, and have only one job; or • You're married filing jointly, have only one job, and your spouse doesn't work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**D**

E **Child tax credit.** See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "4" for each eligible child.
- If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "2" for each eligible child.
- If your total income will be from $175,551 to $200,000 ($339,001 to $400,000 if married filing jointly), enter "1" for each eligible child.
- If your total income will be higher than $200,000 ($400,000 if married filing jointly), enter "-0-" . . . . . **E**

F **Credit for other dependents.**

- If your total income will be less than $69,801 ($101,401 if married filing jointly), enter "1" for each eligible dependent.
- If your total income will be from $69,801 to $175,550 ($101,401 to $339,000 if married filing jointly), enter "1" for every two dependents (for example, "-0-" for one dependent, "1" if you have two or three dependents, and "2" if you have four dependents).
- If your total income will be higher than $175,550 ($339,000 if married filing jointly), enter "-0-" . . . . . **F**

G **Other credits.** If you have other credits, see Worksheet 1-6 of Pub. 505 and enter the amount from that worksheet here . . **G**

H Add lines A through G and enter the total here . . . . . ▸ **H** 0

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, or if you have a large amount of nonwage income and want to increase your withholding, see the **Deductions, Adjustments, and Additional Income Worksheet** below.
- If you **have more than one job at a time** or are **married filing jointly and you and your spouse both work**, and the combined earnings from all jobs exceed $52,000 ($24,000 if married filing jointly), see the **Two-Earners/Multiple Jobs Worksheet** on page 4 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 above.

Deductions, Adjustments, and Additional Income Worksheet

Note: Use this worksheet *only* if you plan to itemize deductions, claim certain adjustments to income, or have a large amount of nonwage income.

1	Enter an estimate of your 2018 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your income. See Pub. 505 for details	**1** $
2	Enter: $24,000 if you're married filing jointly or qualifying widow(er); $18,000 if you're head of household; $12,000 if you're single or married filing separately	**2** $
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	**3** $
4	Enter an estimate of your 2018 adjustments to income and any additional standard deduction for age or blindness (see Pub. 505 for information about these items)	**4** $
5	**Add** lines 3 and 4 and enter the total	**5** $
6	Enter an estimate of your 2018 nonwage income (such as dividends or interest)	**6** $
7	**Subtract** line 6 from line 5. If zero, enter "-0-". If less than zero, enter the amount in parentheses	**7** $
8	**Divide** the amount on line 7 by $4,150 and enter the result here. If a negative amount, enter in parentheses. Drop any fraction	**8**
9	Enter the number from the **Personal Allowances Worksheet,** line H above	**9**
10	**Add** lines 8 and 9 and enter the total here. If zero or less, enter "-0-". If you plan to use the **Two-Earners/ Multiple Jobs Worksheet,** also enter this total on line 1, page 4. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	**10**

This form is only used to estimate the Federal taxes that you wish to have deducted from your paycheck. Do NOT submit this form. Please enter the results of your calculations on the form on the Substitute W-4 provided with this packet.

This form is only used to estimate the Federal taxes that you wish to have deducted from your paycheck. Do NOT submit this form. Please enter the results of your calculations on the form on the Substitute W-4 provided with this packet.

Two-Earners/Multiple Jobs Worksheet

Note: Use this worksheet *only* if the instructions under line H from the **Personal Allowances Worksheet** direct you here.

1	Enter the number from the **Personal Allowances Worksheet,** line H, page 3 (or, if you used the **Deductions, Adjustments, and Additional Income Worksheet** on page 3, the number from line 10 of that worksheet)	**1**	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you're married filing jointly and wages from the highest paying job are $75,000 or less and the combined wages for you and your spouse are $107,000 or less, don't enter more than "3"	**2**	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	**3**	

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

4	Enter the number from line 2 of this worksheet	**4**	
5	Enter the number from line 1 of this worksheet	**5**	
6	**Subtract** line 5 from line 4	**6**	0
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	**7**	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	**8**	$ 0
9	**Divide** line 8 by the number of pay periods remaining in 2018. For example, divide by 18 if you're paid every 2 weeks and you complete this form on a date in late April when there are 18 pay periods remaining in 2018. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	**9**	$ 0

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $7,000	0
5,001 - 9,500	1	7,001 - 12,500	1
9,501 - 19,000	2	12,501 - 24,500	2
19,001 - 26,500	3	24,501 - 31,500	3
26,501 - 37,000	4	31,501 - 39,000	4
37,001 - 43,500	5	39,001 - 55,000	5
43,501 - 55,000	6	55,001 - 70,000	6
55,001 - 60,000	7	70,001 - 85,000	7
60,001 - 70,000	8	85,001 - 90,000	8
70,001 - 75,000	9	90,001 - 100,000	9
75,001 - 85,000	10	100,001 - 105,000	10
85,001 - 95,000	11	105,001 - 115,000	11
95,001 - 130,000	12	115,001 - 120,000	12
130,001 - 150,000	13	120,001 - 130,000	13
150,001 - 160,000	14	130,001 - 145,000	14
160,001 - 170,000	15	145,001 - 155,000	15
170,001 - 180,000	16	155,001 - 185,000	16
180,001 - 190,000	17	185,001 and over	17
190,001 - 200,000	18		
200,001 and over	19		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $24,375	$420	$0 - $7,000	$420
24,376 - 82,725	500	7,001 - 36,175	500
82,726 - 170,325	910	36,176 - 79,975	910
170,326 - 320,325	1,000	79,976 - 154,975	1,000
320,326 - 405,325	1,330	154,976 - 197,475	1,330
405,326 - 605,325	1,450	197,476 - 497,475	1,450
605,326 and over	1,540	497,476 and over	1,540

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

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

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

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

This form is only used to estimate the Federal taxes that you wish to have deducted from your paycheck. Do NOT submit this form. Please enter the results of your calculations on the form on the Substitute W-4 provided with this packet

Employee's Withholding Allowance Certificate

2018 Substitute Form W-4

Employer identification number: 53-6002523 F

U. S. House of Representatives
Office of Payroll & Benefits
B215 Longworth HOB
Washington, DC 20515

NAME ' '

Last First Middle

If your last name differs from that on your social security card, call 1-800-772-1213.

ADDRESS 1

ADDRESS 2

CITY STATE ZIP , Select your state,

SOCIAL SECURITY NUMBER

FEDERAL TAX WITHHOLDING

Marital Status: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate

Note: *If married, but legally separated, or spouse is a nonresident alien, check the Single block.*

Total number of allowances you are claiming . . . . . .

Additional amount, if any, you want deducted from each paycheck . . . . . $

I claim exemption from withholding for 2018 and I certify that I meet **ALL** of the following conditions for exemption:

- Last year I had a right to a refund of **ALL** Federal income tax withheld because I had **NO** tax liability; **AND**
- This year I expect a refund of **ALL** Federal income tax withheld because I expect to have **NO** tax liability.

If you meet both conditions, enter "EXEMPT" here > > > > > > >

Under penalties of perjury, I certify that I am entitled to the number of withholding allowances claimed on this certificate or entitled to claim exempt status.

SIGNATURE This document requires a Wet signature. **Date**

STATE TAX WITHHOLDING

I authorize the following action regarding State Income Tax Withholding:

(1) ☐ Begin Withholding (2) ☐ Change Existing Deduction (3) ☐ Stop Withholding

Complete the following information only if Box 1 or 2 is checked above.

STATE: Select your state **County (Maryland residents only):** **Select your MD County**

Marital Status: ☐ Single ☐ Married Select your MD C

If you are a resident of Connecticut, Georgia or Mississippi and claimed Married, select withholding option to the right that you wish to claim. > > > > >

☐ 03 - Married Filing Separate
☐ 04 - Married Both Spouses Working
☐ 05 - Married One Spouse Working
☐ 06 - Head of Household

Total number of allowances you are claiming . . . . . .

Additional amount, if any, you want deducted from each paycheck . . . . . $

SIGNATURE This document requires a Wet signature. **Date**

Withholding of State taxes is a voluntary program with the House of Representatives.
However, employees should pay estimated State taxes in accordance with State law (see following sheet or reverse).

STATE TAX WITHHOLDING REGULATIONS,

1. All election authorizations, revocations, or changes for withholding State tax from salaries must be made on the prescribed form issued by the U.S. House of Representatives, CAO Office of Payroll and Benefits.

2. An employee may have only one request for State withholding in effect at any one time.

3. An employee may not have more than two such requests with respect to different states during any one calendar year.

4. Election for withholding is **optional** and an employee may revoke such election.

5. Election, change, or revocation of State tax withholding is effective on the first day of the month in which the request is processed by the CAO Office of Payroll and Benefits, but in no event later than the first day of the first month beginning after the day on which such election, change, or revocation is received by the Office of Payroll and Benefits, with the following exception: when an employee first receives an appointment, his/her request shall be effective on the day of the appointment if the request is made at that time.

STATE ABREVIATIONS
(For use in completing State Tax Withholding)
TWO-LETTER STATE ABBREVIATIONS

Alabama	AL	Louisiana	KY	Oklahoma	OK
Alaska	AK	Maine	ME	Oregon	OR
Arizona	AZ	Maryland	MD	Pennsylvania	PA
Arkansas	AR	Massachusetts	MA	Puerto Rico	PR
California	CA	Michigan	MI	Rhode Island	RI
Colorado	CO	Minnesota	MN	South Carolina	SC
Connecticut	CT	Mississippi	MS	South Dakota	SD
Delaware	DE	Missouri	MO	Tennessee	TN
District of Columbia	DC	Montana	MT	Texas	TX
Florida	FL	Nebraska	NE	Utah	UT
Georgia	GA	Nevada	NV	Vermont	VT
Hawaii	HI	New Hampshire	NH	Virginia	VA
Idaho	ID	New Jersey	NJ	Washington	WA
Illinois	IL	New Mexico	NM	West Virginia	WV
Indiana	IN	New York	NY	Wisconsin	WI
Iowa	IA	North Carolina	NC	Wyoming	WY
Kansas	KS	North Dakota	ND		
Kentucky	KY	Ohio	OH		

FEDERAL WITHHOLDING

Copies of the Internal Revenue Service *Employee's Personal Allowance Worksheet* for Form W-4 can be obtained from the CAO Office of Payroll and Benefits, B215 Longworth HOB, Washington, DC 20515.

Direct Deposit Form

Instructions:

1. This form can be used to identify up to two (2) direct deposit accounts.
2. Complete all sections of this form, print, and return with all required supporting documents to the Office of Payroll and Benefits.
3. This form(s) ***will not*** be processed if submitted with incomplete information.
4. This form(s) ***will not*** be processed if submitted without an accompanying voided check ***or*** an ACH routing document ***provided by your financial institution***.
5. This office reserves the right to pull back any funds sent to your financial institution in error.
6. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Direct Deposit Form

Date: _____

First Name: _____

Last Name: _____

Employee Social Security Number: _____

Address: _____

City, State Zip: _____, Sele, _____

Email: _____

Daytime Telephone: _____ Evening Telephone: _____

Return the completed form(s) and accompanying documents to:

Office of Payroll and Benefits
B-215 Longworth House Office Building
Washington, D.C. 20515
(202) 225-1435 phone
(202) 225-5969 fax

On this page you may only select a Primary or a Secondary account.

New ☐ Change ☐

Primary Direct Deposit Account
The account you want the balance of your salary to go to.
If you don't have a Secondary Direct Deposit Account, all funds will go to this account.

New ☐ Change ☐ Cancel ☐

Secondary Direct Deposit Account (choose % or $ and enter value below)
A portion of your salary goes to this account.
You must designate either a % (less than 100%) or a dollar value you want sent to this account.

(If secondary Direct Deposit) Enter value for ☐ **%** (less than 100%) ☐

Is this a Checking ☐ or Savings ☐ account?

Financial Institution Name field requires value for page to print

Financial Institution Name: _____

Financial Institution Address: _____

Financial Institution City, State Zip: _____

Financial Institution Phone Number: _____

Affix voided check here (use tape please) – or append ACH routing form from your banking institution

PLEASE READ THE FOLLOWING INFORMATION BEFORE SUBMITTING:

1. These forms ***will not*** be processed without an accompanying voided check ***or*** an ACH routing document ***provided by your financial institution***.
2. This office reserves the right to pull back any funds sent to your financial institution in error.
3. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Signature: _____ **This document requires a Wet signature.**

Direct Deposit Form

Date: _____

First Name: _____

Last Name: _____

Employee Social Security Number : _____

If you would you like to add another (secondary) Direct Deposit Account please fill in the information below, otherwise, print and sign the forms then submit the forms as noted.

Return the completed form(s) and accompanying documents to:

Office of Payroll and Benefits
B-215 Longworth House Office Building
Washington, D.C. 20515
(202) 225-1435 phone
(202) 225-5969 fax

New ☐ Change ☐ Cancel ☐

Secondary Direct Deposit Account

(Enter either a % or an amount)

A portion of your salary goes to this account.
You must designate either a % (less than 100%) or a dollar value you want sent to this account

Enter value for 0 **%** (less than 100%) OR **$** 0.00

Is this a Checking ☐ or Savings ☐ account?

Financial Institution Name field requires value for page to print

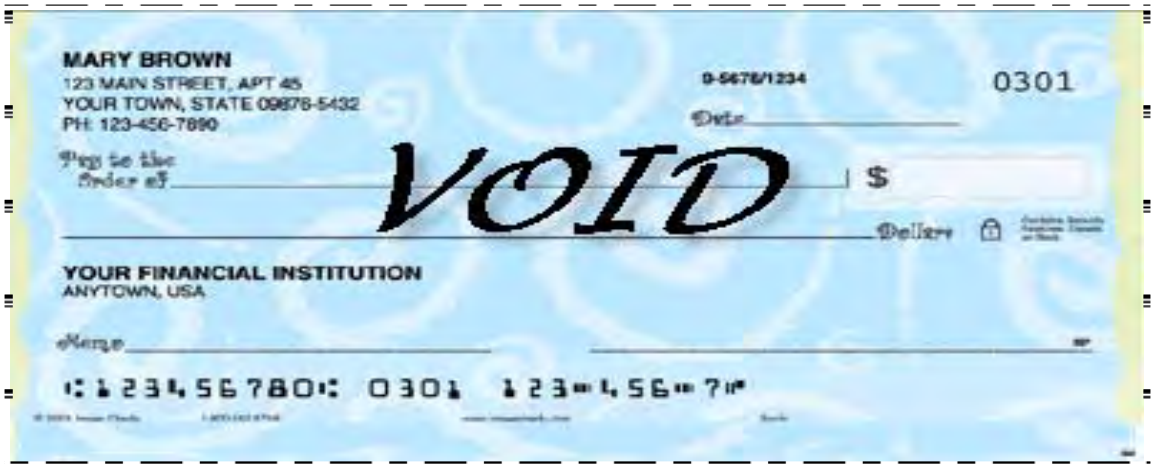
Financial Institution Name: _____

Financial Institution Address: _____

Financial Institution City, State Zip: _____

Financial Institution Phone Number: _____

Affix voided check here (use tape please) – or append ACH routing form from your banking institution



PLEASE READ THE FOLLOWING INFORMATION BEFORE SUBMITTING:

4. These forms ***will not*** be processed without an accompanying voided check ***or*** an ACH routing document ***provided by your financial institution***.
5. This office reserves the right to pull back any funds sent to your financial institution in error.
6. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Signature: **This document requires a Wet signature.** _____

THRIFT SAVINGS PLAN
ELECTION FORM

@Mail.House.GOV

TSP-1

Use this form to start, stop, or change the amount of your contributions to the Thrift Savings Plan (TSP).

Before completing this form, please read the *Summary of the Thrift Savings Plan* and the instructions on the back of this form. Type or print all information. **Return the completed form to your agency personnel or benefits office.** Your agency should return a copy to you after completing Section V.

Note: To choose your investment funds, see the instructions in the General Information section on the back of this form.

I. INFORMATION ABOUT YOU

1. , ,
Name *(Last)* *(First)* *(Middle)*

2. , Select your state,
Street Address City State Zip Code

3. _____ _____ – _____
Social Security Number

4. _____ _____ _____
Daytime Phone *(Area Code and Number)*

5. US HOUSE OF REPRESENTATIVES
Office Identification *(Agency and Organization)*

II. CHOOSE THE AMOUNT OF YOUR CONTRIBUTIONS

Your choice will cancel all previous elections.

To start or change the amount of traditional (pre-tax) or Roth (after-tax) contributions to your TSP account, enter **either** a whole percentage of your basic pay per pay period **or** a whole dollar amount per pay period for each type of contribution you elect. (You may choose a percentage for one type of contribution and a dollar amount for the other type of contribution.) **Remember:** A blank line next to a type of contribution equals 0% or $0 contributed.

6. Traditional (Pre-Tax) Contributions _____ .0% **OR** **7.** $ _____ .00

8. Roth (After-Tax) Contributions _____ .0% **OR** **9.** $ _____ .00

Contact the Office of Payroll & Benefits at (202) 225-1435 before electing a dollar amount.

III. STOP SOME OR ALL OF YOUR CONTRIBUTIONS

To stop all or just one type of your contributions to the TSP, check the box in Item 10 that applies and complete Section IV. Your payroll contributions will stop no later than the first full pay period after your agency employing office receives this form. (If you are a Federal Employees Retirement System [FERS] employee and you stop your contributions, your Agency Matching Contributions will stop, but Agency Automatic [1%] Contributions will continue. Read the instructions on the back.)

10. ☐ I choose not to save for my retirement. Please stop all my payroll contributions to my TSP account.

☐ Stop only my traditional (pre-tax) payroll contributions to my TSP account.

☐ Stop only my Roth (after-tax) payroll contributions to my TSP account.

If you are a newly hired (or rehired) employee, you can generally stop your automatic employee contributions before they start if you submit this form to your agency before the end of your first full pay period. (See note on back.)

IV. SIGNATURE

11. **This document requires a Wet signature.**
Participant's Signature

12. _____
Date Signed *(mm/dd/yyyy)*

V. FOR EMPLOYING OFFICE USE ONLY

13. 00004832
Payroll Office Number

14. ___/___/___
Receipt Date *(mm/dd/yyyy)*

15. ___/___/___
Effective Date *(mm/dd/yyyy)*

16. **This document requires a Wet signature.**
Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request the information you provide on this form under 5 U.S.C. chapter 84, Federal Employees Retirement System. Your agency or service will use this information to identify your TSP account and to start, change, or stop your TSP contributions. In addition, this information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. The information may also be shared with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. Relevant portions of the information may also be disclosed to appropriate parties engaged in litigation and for other routine uses as specified in the Federal Register. You are not required by law to provide this information, but if you do not provide it, your agency or service will not be able to process your request.

Contact the Office of Payroll & Benefits at (202) 225-1435 before electing a dollar amount.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

Form TSP-1 (9/2015)
PREVIOUS EDITIONS OBSOLETE

TSP-1, INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

You may start, stop, or change your contributions at any time. Your TSP election will stay in effect until you submit another election or until you leave Federal service. (This form only applies to regular contributions. If you are age 50 or older and want to make or change catch-up contributions, use Form TSP-1-C, Catch-Up Contribution Election.)

Important note for new TSP participants: All contributions to your account will be invested in the Lifecycle (L) Fund targeted most closely to the year you turn 62 unless you direct the TSP to allocate your contributions differently. The TSP publication *Summary of the Thrift Savings Plan* describes all of your investment choices and discusses their risks and advantages. For more information, you can also obtain a copy of the TSP Fund Information sheets. (The most current versions of TSP forms and publications are available on the TSP website at tsp.gov.)

To choose your investment fund(s), use the TSP website (tsp.gov) or the ThriftLine at 1-TSP-YOU-FRST (1-877-968-3778; outside the U.S. and Canada, call 404-233-4400). On the TSP website, you will need your TSP account number (or user ID) and Web password. If you use the ThriftLine, you will need your TSP account number and ThriftLine Personal Identification Number (PIN). If you are a new participant, your TSP account number, ThriftLine PIN, and Web password will be mailed to you (separately) after your account has been established.

If you change your address, notify your **agency** immediately to correct your records for your TSP account.

SECTION I

Complete all items in this section.

SECTION II

Your choice will cancel all previous elections.

Example

Previous Election:

Traditional **5%**
Roth **2%**

New Election:

Traditional **5%**
Roth **10%**

Complete this section to start your TSP contributions or to change the amount and type of contributions. Because whatever you enter in this section will cancel all previous elections, be sure to indicate exactly what percentages/amounts you want to contribute, even if part of your election has not changed (see the example in the margin). You can elect to make traditional (pre-tax) and Roth (after-tax) contributions simultaneously. **Traditional contributions** come out of your pay **before** income taxes are calculated; you pay income taxes on these contributions and their earnings when you withdraw them. **Roth contributions** are made from your pay **after** taxes, and the earnings grow in your account tax-deferred. Withdrawals of Roth contributions are tax-free. The earnings associated with Roth contributions are also tax-free, but only if 5 years have passed since January 1 of the calendar year in which you made your first Roth contribution, **and** you have reached age 59½, have a permanent disability, or have died. **Note for FERS:** All agency contributions to your account are tax-deferred, even if they are matching your Roth contributions.

Complete **either** Item 6 **or** Item 7 (not both) for traditional (pre-tax) contributions; **either** Item 8 **or** Item 9 (not both) for Roth contributions. You may choose a percentage of basic pay for one type of contribution and a dollar amount (as little as $1) for the other type of contribution.

If you choose a percentage of basic pay, your contribution amount will automatically increase when you receive a pay raise.

If you choose a dollar amount per pay period, your contribution amount will not increase when you receive a pay raise; you must submit a new Form TSP-1 to change the amount.

Contribution limit. The **total** of your traditional and Roth contributions cannot exceed the Internal Revenue Code (IRC) annual elective deferral limit, which may change each year. For the current limit, visit "Contribution Limits" at tsp.gov.

SECTION III

Complete Item 10 to stop all or just one type of your contributions. You may restart your contributions at any time.

FERS employees: Your Agency Automatic (1%) Contributions will continue after you stop your employee contributions, but you will no longer receive valuable Agency Matching Contributions. (If you restart your contributions, the matching contributions will resume.)

Note for newly hired or rehired FERS or CSRS employees: Your agency automatically deducts 3% of your pay, tax-deferred, and deposits the money in your TSP account for your retirement savings. If you want all or any portion of your automatic contributions to be after-tax Roth contributions, **you must complete Section II** and indicate what percentages or amounts you want as traditional (pre-tax) and Roth (after-tax) contributions. You can stop your automatic employee contributions before they start if you submit this form to your agency at the start of your first full pay period, subject to your agency's processing deadlines. If your agency has already begun to deduct your automatic employee contributions from your pay each pay period, you are entitled to request a refund of your initial contributions by submitting Form TSP-25, Automatic Enrollment Refund Request. The TSP must receive Form TSP-25 within 90 days of your first contribution.

SECTION IV

You must complete this section.

SECTION V

(To be completed by personnel or benefits office)

The Receipt Date (Item 14) is the date that a **properly completed** form is received by the agency personnel office. If the form has not been properly completed, it should be returned to the employee.

Requests must be processed immediately for new and rehired employees who want to stop automatic enrollment before it begins. This will help avoid a payroll deduction that may have to be refunded. The Effective Date (Item 15) must be no later than the first full pay period after receipt of a properly completed form.

You should provide the participant with a copy of this completed election form.

U.S. House of Representatives
Washington, D.C. 20515

Certificate of Relationship/Nonrelationship to Any Current Member of Congress

Date _____

To: _____
(Employing Authority)

☐ I certify that I do not have any of the following relationships to any current Member of Congress.

father	nephew	sister-in-law
mother	niece	stepfather
son	husband	stepmother
daughter	wife	stepson
brother	father-in-law	stepdaughter
sister	mother-in-law	stepbrother
uncle	son-in-law	stepsister
aunt	daughter-in-law	half-brother
first cousin	brother-in-law	half-sister

☐ I certify that I am the _____ of the
(Relationship)

Honorable _____.
(Name of Member to whom related)

This document requires a Wet signature.

_____
(Employee)

U.S. GOVERNMENT PRINTING OFFICE: 1995 87–660 (Mac)

U.S. House of Representatives
Principles of Behavior for Information System Users

GUIDELINES FOR USE OF INFORMATION SYSTEMS

The following principles apply to House employees and contractors using or providing support for House information systems. Additional guidance unique to specialized systems may be provided as needed. These principles are based on Federal law, the House Code of Official Conduct, Committee on House Administration (CHA) Regulations, and House Information Security Policies (HISPOLs). At the discretion of the Employing Authority, there may be consequences for non-compliance.

USERS ARE RESPONSIBLE FOR ALL ACTIONS PERFORMED WITH THEIR PERSONAL USER ID.

- Users shall make every effort to protect information security through effective use of user IDs and passwords.
- User IDs and passwords are for individual use only.
- Users must not disclose their passwords to anyone. Users must take necessary steps to prevent anyone from gaining knowledge of their passwords.

REGULATIONS, POLICIES, AND PROCEDURES MUST BE FOLLOWED.

- House information systems may not be used contrary to public law, House Rules, CHA regulations, and HISPOLs.
- All computer resources assigned, controlled, assessed, and maintained by House employees and contractors are subject to periodic test, review, and audit.

ACCESS TO INFORMATION MUST BE CONTROLLED.

- Users must access and use only information for which they have official authorization.
- Users must protect information from unauthorized disclosure or modification.
- Users must protect information so that it is available on a timely basis to meet House operational requirements.

USERS ARE RESPONSIBLE FOR THE PROPER USE OF COMPUTER RESOURCES.

- Users are accountable for their own actions and responsibilities related to information and information systems entrusted to them.
- Users must protect computer equipment from damage, abuse, theft, sabotage, and unauthorized use.
- Users must use approved software in a safe manner so that it is protected from damage, abuse, theft, sabotage, and unauthorized replication or use (copyright infringement).
- Users must participate in annual security awareness training to ensure their knowledge of current policies and procedures.
- Users must report suspected security violations, incidents, and vulnerabilities to the Information Systems Security Office.

USER CERTIFICATION

I certify that I have read the above statements, fully understand my responsibilities, and agree to comply. I recognize that any violation of the requirements indicated above may be cause for disciplinary actions.

Name (please print): _____

Signature: **This document requires a Wet signature.**

Date: _____

The following pages are optional forms that do NOT have to be completed on the date of hire. If you wish to apply for these benefits you MUST apply by the deadlines noted below.

Program	Form	Time Limit for application
TSP	TSP-1C	For Staffers age 50 and over, they may enroll at any time. Staff enrolling in TSP Catch-Up, should also be participating in TSP Tradition or TSP Roth.
Health (FEHB)	SF-2809	Staff eligible for the FEHB Program must enroll within **60 days** of their appointment date of hire **or** enroll on-line at EBIS, https://hor.benefitsinfo.net/login.aspx
Health (DC SHOP)	Online Only	Staff designated to participate in the Public Exchanges for health insurance must enroll within **30 days** of their appointment date of hire on-line at https://www.dchealthlink.com/
Life	SF-2817	Staff are automatically enrolled in Basic Life Insurance unless they submit a waiver of life insurance coverage. Staff have **60 days**, from the date of their appointment, to elect optional Life Insurance coverage.

Supplemental Dental and Vision enrollment is conducted on-line at www.benefeds.com Within **60 days** of your appointment.

Flexible Spending Account enrollment is conducted on-line at www.FSAFEDS.com Within **60 days** of your appointment.

TSP-1-C, INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

Catch-up contributions are in addition to your regular TSP contributions. Therefore, if you are not already contributing the maximum amount allowed by the Internal Revenue Code (IRC) through your regular TSP contributions or by contributing to an equivalent employer plan (e.g., a 401(k) plan), you must elect to contribute the maximum amount before you are eligible to make catch-up contributions. The IRC annual elective deferral limit for 2015 and 2016 is $18,000. Your catch-up election **will not** affect your regular TSP contributions.

You may start, stop, or change your catch-up contributions at any time. Your election will stay in effect subject to the conditions in Section II below. You must make a new election for each calendar year.

You do not receive matching contributions from your agency for any catch-up contributions.

Your catch-up contribution election will be effective no later than the first full pay period after your agency receives it. Contributions will be invested according to your most recent contribution allocation on file. If you wish to change your contribution allocation, you may do so on the TSP website at tsp.gov, or the ThriftLine at 1-TSP-YOU-FRST (1-877-968-3778; outside the U.S. and Canada, call 404-233-4400).

SECTION I

Complete all items in this section.

SECTION II

Your choice will cancel all previous elections.

Your contribution election. You can elect to make traditional (pre-tax) and Roth (after-tax) catch-up contributions simultaneously. Whatever you enter in this section will cancel all previous elections; therefore, be sure to indicate exactly what amounts you want to contribute, even if part of your election has not changed. **Traditional contributions** come out of your pay **before** income taxes are calculated; you pay income taxes on these contributions and their earnings when you withdraw them. **Roth contributions** are made from your pay **after** taxes. Withdrawals of Roth contributions are tax-free. The earnings associated with these contributions are also tax-free, but only if 5 years have passed since January 1 of the calendar year in which you made your first Roth contribution, **and** you have reached age 59½, have a permanent disability, or have died.

Contribution limits. The Internal Revenue Code (IRC) limit for catch-up contributions is $6,000 in 2015 and 2016. The **total** of your traditional and Roth catch-up contributions cannot exceed this limit. IRC limits may be adjusted annually for inflation. Check the TSP website, tsp.gov, to be sure that you have the most up-to-date limit amount (and the most recent version of this form).

Deductions will be made from your basic pay in the dollar amount you indicate. However:

(1) Catch-up contributions will stop when you have reached the maximum allowable dollar amount for the calendar year.

(2) The catch-up contribution amount you specified cannot exceed the amount of your pay after all other required deductions have been made. (Required deductions include regular TSP contributions and TSP loan payments.)

(3) Your catch-up contributions will **not** continue into the next calendar year.

You are not eligible to make catch-up contributions if you are in nonpay status or if you are ineligible to make TSP contributions because you have made a financial hardship in-service withdrawal within the last 6 months. If you have elected to make catch-up contributions and you subsequently enter a noncontribution period, deductions will stop. Contributions will **not** restart automatically. You must submit a new election when your noncontribution period ends.

You may stop your catch-up contributions at any time by submitting a new Form TSP-1-C to your agency indicating that you want your election to stop. (See Section III.)

You must sign this section. If you do not, your request to start or change your catch-up contributions will be rejected.

SECTION III

If you choose to stop all, or just one type, of your catch-up contributions, you must complete and sign this section. Your election should be effective the first pay period after your agency receives it. You can restart your catch-up contributions at any time, subject to the conditions above. Do **not** complete this section if you have completed Section II. Your election in Section II cancels your previous election.

SECTION IV

(To be completed by personnel or benefits office)

The Receipt Date (Item 13) is the date that a **properly completed** form is received by the agency personnel office. If the form has not been properly completed, it should be returned to the employee.

The Effective Date (Item 14) must be no later than the first full pay period after receipt of a properly completed form.

You should provide the participant with a copy of this completed election form.

THRIFT SAVINGS PLAN
CATCH-UP CONTRIBUTION ELECTION

@Mail.House.GOV **TSP-1-C**

Use this form to start, stop, or change your "catch-up" contribution election to your TSP account. You are eligible to make catch-up contributions **if you are age 50 or older** (or if you will become age 50 during the calendar year for which you are making this election), **and** you are already contributing a percentage or a dollar amount which will result in reaching the Internal Revenue Code (IRC) elective deferral limit by the end of the year. (See back of form.) Catch-up contributions will be taken from your basic pay each pay period and invested according to your most recent contribution allocation; they are in addition to your regular TSP contributions.

Before completing this form, read the information on the back. Type or print all information. **Return the completed form to your agency.**
Active Employees can make TSP enrollment changes via the Employee Benefit Information System, EBIS, located on HouseNet, click here.

I. INFORMATION ABOUT YOU

1. , ,
Name *(Last)* *(First)* *(Middle)*

2. , Select your state,
Street Address City State Zip Code

3. _____ _____ – _____
Social Security Number

4. _____ _____ _____
Daytime Phone *(Area Code and Number)*

5. US HOUSE OF REPRESENTATIVES
Office Identification *(Agency and Organization)*

II. CHOOSE THE AMOUNT OF YOUR CATCH-UP CONTRIBUTIONS

You must be in pay status. (See back of form.)

Your choice will cancel all previous elections.

To start or change your catch-up contributions, complete Items 6, 7, and 8. Use whole dollar amounts. (See additional instructions on the back of the form.) **Remember:** A blank line next to a type of contribution is equal to $0 contributed.

6. I elect to contribute the following catch-up contributions per pay period:

$_____.00 Traditional (Pre-Tax)
$_____.00 Roth (After-Tax)

} Total **cannot exceed $6,000** for the calendar year.

I understand that my election will continue until:

- the end of the calendar year; or
- I reach the annual limit for catch-up contributions; or
- I submit a new election to stop or change these contributions.

I certify that I will make regular contributions to the TSP or an equivalent employer plan up to the maximum amount allowed by the IRS and TSP plan rules. I understand that my catch-up contributions are in addition to my regular TSP contributions.

7. This document requires a Wet signature.
Participant's Signature

8. / /
Date Signed *(mm/dd/yyyy)*

III. STOP SOME OR ALL OF YOUR CATCH-UP CONTRIBUTIONS

I understand that I must make a new election to resume these contributions.

9. I want to stop the catch-up contributions indicated below:

☐ All catch-up contributions
☐ Traditional (pre-tax) catch-up contributions only
☐ Roth (after-tax) catch-up contributions only

10. This document requires a Wet signature.
Participant's Signature

11. / /
Date Signed *(mm/dd/yyyy)*

IV. FOR EMPLOYING OFFICE USE ONLY

12. 00004832
Payroll Office Number

13. / /
Receipt Date *(mm/dd/yyyy)*

14. / /
Effective Date *(mm/dd/yyyy)*

15. This document requires a Wet signature.
Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request the information you provide on this form under 5 U.S.C. chapter 84, Federal Employees' Retirement System. Your agency will use this information to identify your TSP account and to start, change, or stop your TSP contributions. In addition, this information may be shared with other Federal agencies for statistical, auditing, or archiving purposes. The information may also be shared with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order. It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. Relevant portions of the information may also be disclosed to appropriate parties engaged in litigation and for other routine uses as specified in the Federal Register. You are not required by law to provide this information, but if you do not provide it, your agency or service will not be able to process your request.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

Form TSP-1-C (1/2016)
PREVIOUS EDITIONS OBSOLETE

View Instructions

Form Approved:
OMB No. 3206-0160

Federal Employees
Health Benefits Program

Health Benefits Election Form

4. Gender selection required for page to print

Part A - Enrollee and Family Member Information *(for additional family members use a separate sheet and attach)*

1. Enrollee name *(last, first, middle initial)*
, ,

2. Social Security Number

3. Date of birth *(mm/dd/yyyy)*

4. Sex
☐ M ☐ F

5. Are you married?
☐ Yes ☐ No

6. Home mailing address *(including ZIP Code)*
, Select your state,

7. If you are covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

8. Medicare Claim Number

9. Are you covered by insurance other than Medicare?
☐ Yes, indicate in item 10 below. ☐ No

10. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

11. Email address

12. Preferred telephone number

13. Name of family member *(last, first, middle initial)*

14. Social Security Number

15. Date of birth *(mm/dd/yyyy)*

16. Sex
☐ M ☐ F

17. Relationship code

18. Address *(if different from enrollee)*

19. If this family member is covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

20. Medicare Claim Number

21. Is this family member covered by insurance other than Medicare?
☐ Yes, indicate in item 22 below. ☐ No

22. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

23. Email address *(if applicable, enter email address of your spouse or adult child)*

24. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

25. Name of family member *(last, first, middle initial)*

26. Social Security Number

27. Date of birth *(mm/dd/yyyy)*

28. Sex
☐ M ☐ F

29. Relationship code

30. Address *(if different from enrollee)*

31. If this family member is covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

32. Medicare Claim Number

33. Is this family member covered by insurance other than Medicare?
☐ Yes, indicate in item 34 below. ☐ No

34. Indicate the type(s) of other insurance:
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

35. Email address *(if applicable, enter email address of your spouse or adult child)*

36. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

37. Name of family member *(last, first, middle initial)*

38. Social Security Number

39. Date of birth *(mm/dd/yyyy)*

40. Sex
☐ M ☐ F

41. Relationship code

42. Address *(if different from enrollee)*

43. If this family member is covered by Medicare, check all that apply.
☐ A ☐ B ☐ D

44. Medicare Claim Number

45. Is this family member covered by insurance other than Medicare?
☐ Yes, indicate in item 46 below. ☐ No

46. Indicate the type(s) of other insurance
☐ TRICARE ☐ Other *Name of other insurance:* _____ *Policy Number:* _____
☐ FEHB *An FEHB Self Plus One enrollment covers the enrollee and one eligible family member designated by the enrollee. An FEHB Self and Family enrollment covers the enrollee and all eligible family members. No person may be covered under more than one FEHB enrollment. See instructions for item 10 on page 1.*

47. Email address *(if applicable, enter email address of your spouse or adult child)*

48. Preferred telephone number *(if applicable, enter preferred phone number of your spouse or adult child)*

(Continued on the reverse)

For agency distribution of copies, see page 5 of the instructions.

Enrollee name: _____ Date of birth: _____

Part B - FEHB Plan You Are Currently Enrolled In ***(if applicable)***

1. Plan name
2. Enrollment code

Part C - FEHB Plan You Are Enrolling In or Changing To

1. Plan name
2. Enrollment code

Part D - Event That Permits You To Enroll, Change, or Cancel ***(see page 2)***

1. Event code
2. Date of event

Part E - Election NOT to Enroll ***(Employees Only)***

☐ I do NOT want to enroll in the FEHB Program.

My signature in Part H certifies that I have read and understand the information on page 3 regarding this election.

Part F - Cancellation of FEHB

☐ I CANCEL my enrollment.

My signature in Part H certifies that I have read and understand the information on page 3 regarding cancellation of enrollment.

Part G - Suspension of FEHB ***(Annuitants/Former Spouses Only)***

☐ I SUSPEND my enrollment.

My signature in Part H certifies that I have read and understand the information on page 4 regarding suspension of enrollment.

Part H - Signature

WARNING: Any intentionally false statement in this application or willful misrepresentation relative thereto is a violation of the law punishable by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001.)

1. Your signature *(do not print)*

This document requires a Wet signature.

2. Date *(mm/dd/yyyy)*

Part I -To be completed by agency or retirement system

REMARKS

1. Date received *(mm/dd/yyyy)*
2. Effective date of action *(mm/dd/yyyy)*
3. Personnel telephone number: (202) 225-1435
4. Name and address of agency or retirement system: Office of Payroll & Benefits, U.S. House of Representatives, B215 Longworth HOB, Washington, DC 20515
5. Authorizing official *(please print)*
6. Signature of authorized agency official
7. Payroll office number: 00004832
8. Payroll office contact *(please print)*: Payroll & Benefits Generalist
9. Payroll telephone number: (202) 225-1435

Standard Form 2809
Reverse of revised November 2015
Previous edition is not usable

FEGLI
Federal Employees' Group Life Insurance

Life Insurance Election

Federal Employees' Group Life Insurance Program

See Privacy Act Statement on back of Part 3

Form Approved:
OMB No. 3206-0230

1 **General Instructions**

By law, unless you waive all coverage or are ineligible, you are automatically covered for Basic life insurance as an employee. When you first become eligible for FEGLI, you may (1) do nothing and have Basic automatically, (2) elect Basic and any or all of the options, or (3) waive all life insurance coverage. If you are changing a previous election, see the back of Part 3 - Employee Copy.

- Read the back of Part 3 - Employee Copy carefully.
- Assignees completing this form should read Items 5 and 6 on the back of Part 3.
- Give all parts of your completed form to your employing office. Your employing office will complete Section 6 of this form (or its electronic equivalent) and return your copy to you.

This election supersedes all previous elections.

2 Fill in identifying information concerning the employee.

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

Employing department or agency	OWCP claim number, if applicable	Location of department or agency where you work *(city, state, ZIP code)*	Daytime telephone number *(including area code)*
U.S House of Representatives		B215 LHOB, Washington, DC, 20515	

3 **To elect or retain Basic,** sign and date below. If you do not sign for Basic, you (or your assignee) may not elect or retain any form of optional insurance. If you do not want any insurance at all, skip to Section 5.

Basic

I want Basic. I authorize deductions to pay my share of the cost. (Basic may be provided without cost to U.S. Postal Service employees.)

SIGNATURE *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* → This document requires a Wet signature.

Date *(mm/dd/yyyy)*

4 **Optional**

If you signed for Basic in item 3 above, you may elect or retain any or all of the following options (UNLESS you have previously waived any or all of these options, in which case you may elect only those options which you are eligible to elect as outlined in the FEGLI Program Booklet). Sign the box(es) below for any option(s) you are eligible for and wish to elect or retain. If you do not sign for an option, you have waived it and your future opportunities to enroll in it are strictly limited.

You will not be covered for any option(s) for which you do not sign below, regardless of whether you previously elected the option(s).

Option A - Standard	Option B - Additional	Option C - Family
I want Option A. I authorize deductions to pay the full cost. ☐ Clear Life Options	I want Option B in the multiple of my annual basic pay I indicate below. I authorize deductions to pay the full cost. ☐ 1 times my pay ☐ 2 times my pay ☐ 3 times my pay ☐ 4 times my pay ☐ 5 times my pay	I want Option C in the multiple I indicate below. I understand that each multiple is worth $5,000 upon the death of my spouse, and $2,500 upon the death of an eligible child. I authorize deductions to pay the full cost. ☐ 1 multiple ☐ 2 multiples ☐ 3 multiples ☐ 4 multiples ☐ 5 multiples
SIGNATURE *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* →	**SIGNATURE** *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* →	**SIGNATURE** *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* →
Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*	Date *(mm/dd/yyyy)*

5 **If you want NO life insurance coverage,** sign and date below.

Waiver of all life insurance coverage

I want NO life insurance coverage. I understand that any life insurance I have will stop at the end of the last day of the pay period in which my employing office receives this waiver. Further, I cannot get Basic life insurance unless (1) I wait at least 1 year after I sign this form and submit satisfactory medical information, or (2) I experience a life event, or (3) I have a break in Federal service of at least 180 days, or (4) I participate in an open season, which is held infrequently. I understand that I cannot get any optional insurance unless I first have Basic. I understand that my decision to waive life insurance coverage now may affect my eligibility for coverage as a retiree.

SIGNATURE *(Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are* ***not*** *valid.)* → This document requires a Wet signature.

Date *(mm/dd/yyyy)*

6 **Agency Use** ***Remarks:***

If new/newly eligible employee, enter "0" for event.

Number of event permitting change *(See back of Part 2)*

Name and address of employing office	Date received in employing office *(mm/dd/yyyy)*	Effective date of coverage *(mm/dd/yyyy)*
U.S. House of Representatives CAO Office of Payroll and Benefits B215 Longworth House Office Building Washington, DC 20515-6604		

I followed the instructions on the back of Part 1.

Signature of authorized agency official

The employee's copy of this form, when completed by the employing office, together with the FEGLI Program Booklet (FE 76-21 or FE 76-20 for U.S. Postal Service employees) constitute the employee's Certificate (proof) of Insurance.

PART 3 - Employee Copy

U.S. Office of Personnel Management
www.opm.gov/insure/life

Previous edition is not usable.

Standard Form 2817
Revised November 2011

Instructions for Agencies

1. Who Should File This Form?

- New employees eligible for life insurance who want optional insurance or no insurance. **Note:** New employees who want only Basic do not have to file.
- Employees appointed to positions that allow life insurance coverage following service in positions that did not allow life insurance coverage.
- Employees who want to change their life insurance.
- Reinstated employees who filed a previous waiver of any type of life insurance, were separated from service for at least 180 days, and wish to elect coverage.
- Assignees who want to decrease or cancel coverage.
- Department of Defense employees designated "emergency essential" and civilian employees deployed in support of a contingency operation per Public Law 110-417.

Give a new employee a copy of the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) when he or she reports for duty and ask the employee to return the completed SF 2817 as soon as possible (preferably before the end of the first pay period), but no later than 60 days after his or her appointment.

Employees with prior government service in non-excluded positions who were separated after March 31, 1981, should have an SF 2817 on file in their personnel folders, and that election or waiver of coverage may still be in effect. **Do not accept a new SF 2817 unless the employee has a break in Federal service of at least 180 days or is eligible to cancel a previous waiver that has been in effect for at least one year, or wishes to reduce coverage.**

Until you verify an employee's SF 2817 on file, make deductions based on his or her statement about earlier insurance coverage. Once coverage is confirmed, make any necessary adjustments to correct the withholdings.

An employee may at any time file an SF 2817 to waive or reduce coverage, **unless** the employee has assigned his/her insurance coverage. If the employee has assigned the insurance, **only** the assignee(s) may waive or reduce the coverage (except for Option C which cannot be assigned).

2. How Else Can An Employee Elect More Coverage?

- **Provide Medical Information.** An employee may elect or increase Basic, Option A, or Option B insurance (but **not** Option C), if a previously completed SF 2817 waiving coverage has been in effect for more than one year, by submitting satisfactory evidence of insurability via a *Request for Insurance*, SF 2822. If approved, the employee should make the election on the SF 2817 and submit to the employing agency. More details are contained on the SF 2822.
- **Experience A Qualifying Life Event.** An employee may elect Basic, Option A, Option B and/or Option C within 60 days following a FEGLI qualifying life event. These events are: marriage, divorce, spouse's death, or the acquisition of an eligible child.

  For Option B and Option C, an employee may elect from 1 to 5 multiples (up to 5 total) based on the life event.
- An employee who is already enrolled in Option B and/or Option C may elect from 1 to 5 multiples (up to 5 total) within 60 days based on the life event.

3. What Should You Review After The Employee Submits This Form?

Review all three parts of the SF 2817 to see that they are legible and complete. If an employee signs the box for Option A, Option B, or Option C, he or she must also sign Section 3, Basic. If the employee uses a downloaded copy, be sure all parts are completed. Contact the employee if any part is unclear.

Only the employee may sign this form in Sections 3, 4, or 5, with one exception (noted below). Signatures by guardians, conservators, or through a power of attorney are ***NOT*** valid.

Exception: If the employee assigned the insurance, only the assignee(s) may ***waive*** or reduce some or all of the employee's coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to the employee). Please note that assignees cannot increase the employee's coverage. Only the employee can do that.

The employee is solely responsible for ensuring that the SF 2817 accurately reflects his or her intentions.

If the employee is electing new coverage, always make sure that the authorized agency official confirms that the employee is eligible for the coverage, and that the official signs the form in Section 6.

4. When Did You Receive This?

Enter the date the employing office received this form.

5. What Is The Event Permitting The Change?

Enter the number of the event permitting a change, if applicable. See the Table of Effective Dates on the back of Part 2 for event numbers.

6. What Is The Effective Date Of The Coverage?

Enter the effective date of coverage. For new and newly eligible employees: Basic is effective on the first day the employee is in a pay and duty status; Optional coverage is effective on the first day the employee is in a pay and duty status on or after the day the employing office receives the SF 2817. For changes in elections, see the Table of Effective Dates on the back of Part 2. If there is more than one effective date for this election, the 2nd effective date should be notated in Part 6 under "Remarks."

7. What Do You Do With Parts 1, 2, and 3?

After completion, give Part 3 to the employee. File Part 1 in the employee's personnel folder. Destroy Part 2 after payroll office use. Part 3, and the *FEGLI Program Booklet* (FE 76-21, or FE 76-20 for U.S. Postal Service employees), serve as the employee's certificate of insurance.

8. Where Can You Find More Information?

Consult the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) or the FEGLI Handbook, which are available on the FEGLI web site at www.opm.gov/insure/life.

For Information Only

Table of Effective Dates: Changes in Life Insurance Coverage

Deductions: Begin, increase, stop or decrease in the same pay period in which coverage begins, increases, stops, or decreases.

Event Allowing Change	Change Permitted? *(To elect any option, employee must elect or retain Basic)*			
	Basic	**Option A - Standard**	**Option B - Additional**	**Option C - Family**
0. New/Newly Eligible Employee:	**Yes.** See "Instructions to Agencies", #5, back of Part 1.	**Yes.** Same as Basic.	**Yes.** Same as Basic.	**Yes.** Same as Basic.
1. **PROVIDING MEDICAL INFORMATION:** Approval of Request for Insurance (SF 2822) by the Office of Federal Employees' Group Life Insurance (OFEGLI).	**Yes. Coverage** is automatically effective the first day the employee is in a pay and duty status on or after date of OFEGLI's approval. **Time Limit** - on or after OFEGLI's date of approval. If employee is not in a pay and duty status within 60 days, Basic does ***NOT*** become effective, and the employee must start over.	**Yes. Coverage** is effective the first day the employee is in a pay and duty status on or after the date of OFEGLI's approval **and** the agency receives the SF 2817. **Time Limit -** Employee must submit the SF 2817 and be in a pay and duty status within 60 days after date of OFEGLI's approval. If employee is not in a pay and duty status or doesn't submit the SF 2817 within those 60 days, Option A does **not** become effective, and the employee must start over.	**Yes.** Same as Option A.	**No.** An employee may ***NOT*** elect Option C by providing medical information.
2. **LIFE EVENT:** Marriage, divorce, death of spouse, or acquisition of an eligible child.	**Yes. Coverage** is effective the day of the event if the SF 2817 is received ***before the event*** and the employee is in pay and duty status ***on the day of the event***. Otherwise, **Coverage** is effective the first day in pay and duty status ***after*** the event and ***after*** receipt of the SF 2817. **Time Limit** - Agency must receive the SF 2817 and proof of the event within 60 days after the day of the event.	**Yes.** Same as Basic. **Coverage** - Same as Basic. **Time Limit** - Same as Basic.	**Yes**. Same as Basic. Employee may elect or increase multiples (up to 5 total). **Coverage -** Same as Basic. **Time Limit** - Same as Basic.	**Yes**. Employee may elect or increase multiples (up to 5 total). If the employee has Basic, **Coverage** is effective the day the employing office receives the election, or the date of the event, whichever is later. If Basic and Option C are elected at the same time, Option C is effective when Basic becomes effective. **Time Limit** - Same as Basic. (Note: If the employee already has Basic, there is no pay and duty status requirement for Option C.)
3. **REINSTATEMENT:** Employee is reinstated after a break in service of at least 180 days in a position that is ***not excluded*** from life insurance by law or regulation.	**Yes. Coverage** is effective on the first day the employee is in a pay and duty status, unless waived by employee.	**Yes.** Employee may elect Option A within 60 days after reinstatement. ***However, if employee does not submit SF 2817 electing coverage within 60 days after reinstatement, s/he has the same Optional insurance carried before the break in service effective the beginning of the reinstatement.***	Same as Option A.	Same as Option A.
4. **REINSTATEMENT:** Employee is reinstated after a break in service of at least 180 days in a position that ***is excluded*** from life insurance by law or regulation.	**No.** However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is in a pay and duty status on or after being converted to such a position.	**No.** However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is in a pay and duty status in the converted position on or after the date the agency receives the SF 2817 electing such coverage. **Time Limit -** Employee must submit the SF 2817 within 60 days after conversion to an eligible position.	Same as Option A.	Same as Option A.
5A. **CANCELING/ WAIVING COVERAGE:** employee/assignee or	A. **Yes.** If the coverage is canceled in the first pay period, no premiums are due. Otherwise, coverage stops at the end of the last day of the pay period in which the agency receives the SF 2817, with **no** 31-day extension of coverage. **Time Limit -** None. Employee may cancel coverage at any time. However, if the insurance is assigned, only the assignee(s) may cancel	A. Same as Basic.	A. Same as Basic.	A. Same as Basic. Option C cannot be assigned. If Option C is canceled because there no longer are eligible family members, the effective date is retroactive to the end of the pay period in which there no longer are any eligible family members. The employing agency must refund Option C premiums retroactive to that effective date.
5B. **REDUCING OPTION B and/or OPTION C MULTIPLES**: employee/assignee	B. Not applicable.	B. Not applicable.	B. **Yes**. Employee may at any time reduce the number of multiples, unless the insurance has been assigned. In that case, only the assignee(s) may reduce coverage – the employee may not. This new coverage is effective at the beginning of the pay period following the one in which the employing office receives the SF 2817.	B. **Yes**. Employee may at any time reduce the number of multiples. This new coverage is effective at the beginning of the pay period following the one in which the employing office receives the SF 2817. Assignee(s) cannot reduce Option C.
6. Open Season.	If permitted under conditions specified by OPM.	Same as Basic.	Same as Basic.	Same as Basic.
7. **CERTAIN DEPT. OF DEFENSE AND CIVILIAN EMPLOYEES AFFECTED BY PUBLIC LAWS 106-398 AND 110-417:**	**Yes,** if employing agency determines employee meets criteria to elect coverage. Coverage is effective the first day the employee is in a pay and duty status on or after the date the agency receives the SF 2817. **Time Limit -** Agency must receive the SF 2817 within 60 days of the date the employee receives official notice of deployment in support of a contingency operation or designation as an emergency essential employee.	Same as Basic. For Information Only	Same as Basic. Employee may elect or increase multiples (up to 5 total).	**No.** An employee may ***NOT*** elect Option C via these provisions of law.

Instructions for Employees

1. General Information
The major provisions of this program are described in the *Federal Employees' Group Life Insurance (FEGLI) Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees). Please read the entire booklet carefully. Your completed copy of this election form (SF 2817) and the FEGLI Program Booklet constitute your certificate (proof) of insurance. These publications, as well as comprehensive FEGLI information, are available at *www.opm.gov/insure/life*.

2. I Am A New Employee or Newly Eligible for Life Insurance. What Do I Need To Know?
You are automatically enrolled in Basic (even if you don't complete this form) unless you waive it. If you waive Basic, you automatically waive all forms of Optional insurance. You will not have any Optional insurance unless you elect it.

To elect Basic: You do not have to submit this form unless you also wish to elect Optional insurance.

To waive Basic: Sign Section 5 of the form and give it to your employing office. Your agency will withhold Basic premiums from your salary from your first day at work in a pay status UNLESS you submit your waiver before the end of your first pay period.

To elect Optional: Sign Section 3 and one or more of the blocks in Section 4 of the form and give it to your employing office within 60 days after the date you are appointed or first become eligible for life insurance.

To waive Optional: If you do not sign for a particular type of Optional coverage in Section 4, ***you automatically waive that coverage***.

3. I Am An Employee With Prior Government Service. What Do I Need To Know?
When you return to work after a break in service of ***less than 180 days***, your human resources office will automatically enroll you in the same coverage that you had before you left your prior position, if any. This coverage will be effective on your first day in a pay and duty status in a FEGLI eligible position. You will have to qualify to elect other coverage (open season, providing medical information, or a life event). If you waived some coverage, then the waiver of that coverage is still in effect.

When you return to work after a break in service of ***180 days or more***, your human resources office will automatically enroll you in Basic and the same Optional insurance that you had in your prior position. This coverage will be effective on your first day in a pay and duty status in a FEGLI eligible position. You may elect more insurance (if you don't already have the maximum) within 60 days of your appointment to an eligible position. If you previously waived coverage then that waiver is no longer in effect. You will automatically be enrolled in Basic, unless you file a new waiver.

See the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service Employees) for more details.

4. I Am A Reemployed Annuitant. What Do I Need To Know?
If you waive your insurance when you return to Federal Service as a reemployed annuitant, you also waive your insurance with your retirement annuity. You will have no FEGLI life insurance. It is important that you contact your human resources office and inform them that you are a reemployed annuitant. More details can be found in OPM Form 1482, *Agency Certification of Status of Reemployed Annuitants*.

5. What If I Assigned My Coverage?
If you have assigned your insurance by filing an RI 76-10, *Assignment of Federal Employees' Group Life Insurance*, you may not cancel any of your insurance coverage (except Option C). Only the assignee(s) may cancel your coverage. However, you may elect new coverage if you otherwise meet the requirements for electing such coverage. Any new coverage you elect will automatically be subject to your existing assignment, except for Option C, which you cannot assign. All assignments are automatically canceled after a break in service of at least 31 days, or upon cancellation of all life insurance coverage by the assignee(s).

6. I Am An Assignee. What Can I Do?
If you are completing this form in order to cancel some or all of the employee's life insurance coverage, you must sign the form. The information in Section 2 of the form refers to the employee, but you must sign in Section 3, 4 or 5, as applicable. Indicate "assignee" after your signature. Return the completed form to the employee's employing office. If the insured is an annuitant, return the completed form to OPM, Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045. See #11 for where to return the completed form if the insured is a compensationer.

7. How Do I Complete The Form?
Follow the instructions for each item carefully. After you fill out the form, review it to be sure it is complete and correct. The following checklist should help.

If you sign Section 3, you elect (or retain) **Basic**.

If you sign any block in Section 4, you elect (or retain) **Optional Insurance**. You must also elect (or retain) Basic by signing Section 3.

If you sign Section 4 for Option B and/or Option C, you must also mark one of the five boxes to show how many multiples you wish to elect (or retain). Do not mark more than one box.

Be Sure You Sign For All Options You Want. This election supersedes all previous ones. If you have optional coverage and wish to keep it, you must sign the appropriate box(es). If you do not sign for it, you have waived it.

If you sign Section 5, you waive all FEGLI coverage.

Only you, the employee, may sign this form. Signatures by guardians, conservators, or through a power of attorney are not acceptable. **Exception:** If you have assigned your insurance, only the assignee(s) may cancel some or all of your coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to you).

REMEMBER THAT YOU, NOT YOUR AGENCY, ARE RESPONSIBLE FOR ENSURING THAT YOUR SF 2817 *(OR ITS ELECTRONIC EQUIVALENT)* IS CORRECT AND ACCURATELY REFLECTS YOUR INTENTIONS. IF YOU DO NOT SIGN FOR IT, YOU HAVE CANCELED/WAIVED IT.

8. Open Seasons
If you elected coverage during an Open Season, and that coverage has not yet become effective, and you want to make a further change to your FEGLI coverage on this SF 2817, you should check with your employing office. That office can tell you about any special election procedures that may apply.

9. What If I Waive or Reduce My Coverage?
If you do not sign for a particular type of coverage, you have waived that coverage. If you waive Basic or one or more of the options, your opportunities to enroll in the coverage you waived are strictly limited. A waiver may also affect your eligibility to continue coverage into retirement. See the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) for more details.

10. Where Do I Send The Completed Form?
After you have completed this form and verified that it accurately reflects your intentions, send the entire form (without separating the parts) to your human resources office. Do ***not*** send the form to OPM or OFEGLI.

11. What If I Receive Workers' Compensation?
If you are receiving compensation payments from the Office of Workers' Compensation Programs (OWCP), provide your OWCP number in Section 2 of the form. If you are still employed, return the completed form to your employing office. If you are not still employed or if you have been receiving compensation payments for at least 12 months, see your human resources office about your continued eligibility under the FEGLI Program.

12. How Do I Verify That My Agency Processed My Election?
After your employing office processes your election form, you will receive an SF 50, *Notification of Personnel Action*. A two digit code appearing on the SF 50 will explain your insurance coverage. These codes are explained in Part 2 of the SF 2817. Also check your pay statement for the correct withholdings. If you are insured as a compensationer, you will receive a notice from OPM which will explain your insurance coverage.

13. Where Do I Get More Information About The FEGLI Program?
Consult the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) or the *FEGLI Handbook* (RI 76-26), which are available on the FEGLI web site at *www.opm.gov/insure/life*.

Privacy Act and Public Burden Statements

Chapter 87, title 5, U.S. Code, Federal Employees' Group Life Insurance, authorizes solicitation of this information. The data you furnish will be used to determine your life insurance coverage. This information may be shared and is subject to verification, via paper, electronic media, or through the use of the computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs or law enforcement agencies, when they are investigating a violation or potential violation of civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number to distinguish between the applicant and people with similar names. Failure to furnish the requested information may result in your agency's inability to determine your life insurance coverage.

We estimate this form takes an average of 15 minutes to complete including the time for getting the needed data and reviewing both the instructions and completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management (OPM), Retirement Services Publications Team (3206-0230), Washington, DC 20415-3430. The OMB Number, 3206-0230 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

U.S. HOUSE OF REPRESENTATIVES
OATH OF OFFICE
PAYROLL AND BENEFITS INFORMATION

PLEASE USE TYPEWRITER OR PRINT IN INK

A. IDENTIFICATION:

, ,

Name: Last-First-Middle

Date of Birth (Month/Day/Year)

Social Security Number

Office Telephone Number (Include Area Code)

Employing Office

Home Telephone Number (Include Area Code)

B. MAILING ADDRESS FOR EARNINGS STATEMENT AND W-2:

, Select your state,

IN ORDER TO RECEIVE ANY PAY FOR SERVICES, all new and returning employees, and employees taking a break in service must complete Parts C through H.

C. OATH OF OFFICE:

I, _____, do solemnly swear (or affirm) that I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

This document requires a Wet signature.

Signature (Required for Appointment)

Date

D. BENEFITS DEADLINE ACKNOWLEDGEMENT:

I understand that from the date of my appointment, I must enroll in Health Benefits (SF2809) within 60 days, if eligible for FEHB. Failureto submit the Health Benefits (SF2809) form within 60 days of the date of appointment will exclude me from FEHB enrollment, in most cases, until Open Season or a qualifying life event (QLE). If deemed to be covered by health exchanges created under the Affordable Care Act (ACA), I understand that I have 30 days to register with the DC Health Insurance Marketplace at www.dchealthlink.com. Thrift Savings Plan (TSP-1) elections are required with all New employee Appointment packages. I have 60 days to elect additional optional life insurance unless a prior election remains in force. Basic premiums for Life Insurance will be withheld from my pay unless I submit a waiver (SF2817) before the 15th of the month. I have 60 days from the date of my appointment to apply for abbreviated underwriting under the Federal Long Term Care (LTC) Insurance Program. I have 60 days from the date of my appointment to apply for the Flexible Spending Accounts (FSAFEDS), or the Dental & Vision Insurance Program (FEDVIP) programs.

This document requires a Wet signature.

Signature (Required for Appointment)

Date

E. WORKERS COMPENSATION INFORMATION:

I ☐ have ☐ have not, received or made application for loss wage compensation under the Federal Employees Compensation Act (job-related injury).

If you have, show: Claim Number _____ Period of Compensation – From: _____ To: _____

SSN:_____

F. PREVIOUS FEDERAL CIVILIAN SERVICE:

1. House of Representatives ☐ Yes ☐ No If Yes, last termination date _____
2. **Other Federal Civilian Service** ☐ Yes ☐ No If Yes, last termination date _____
3. PLEASE LIST BELOW ALL PRIOR FEDERAL CIVILIAN SERVICE: **Include the Senate, Architect of the Capitol, the District of Columbia or a Non-Appropriated Fund Instrumentality (NAFI). (Do not include unpaid internships). (Do not include Active Duty Military Service - See Section 5 below).**

Department or Agency	Date Appointed	Date Separated

Last Personnel Office Phone Number _____

4. While employed as above, my benefits status was:
   (a) Federal Employees' Health Benefits (FEHB) / Health Exchanges:
   ☐ Enrolled (FEHB) _____ Enrollement Code (FEHB) ☐ Not Enrolled (FEHB) ☐ Health Exchange ☐ Excluded
   (b) Federal Employees' Life Insurance: Basic ☐ A ☐ B ___ x Times Did You Port Option B? ☐ Y ☐ N
   C ___ x Times ☐ Waived ☐ Excluded
   (c) Do you have a FEGLI court order on file? ☐ Yes ☐ No
   (d) Covered by: ☐ FICA ☐ FICA/FERS ☐ FICA/FERS RAE ☐ FICA/Furt RAE ☐ FICA/CSR Offset ☐ CSR only
   Transfer to FERS: ☐ Yes ☐ No
   Thrift Savings Plan employee contribution: $ _____ or _____ %
   TSP 50+ Catchup Contribution $_____
   Do you have a current TSP Loan? ☐ Yes If Yes, loan payment amount _____ ☐ No
   (e) Refund of CSR contributions: ☐ Yes Date of Refund: _____ ☐ No
   (f) Federal Long Term Care (LTC) Program

   If you currently have LTC and are paying by payroll deduction, the House does not currently provide payroll deduction option for this benefit and you must arrange for an alternative form of payment.
5. **Active Military Service - Branch:** _____ From: _____ To: _____
   (a) Are you returning from Active Military Service which interrupted your Federal Civilian Service? ☐ Y ☐ N
6. Other Names Used (if different from your present signature): _____
7. I took a Voluntary Separation Incentive. ☐ Yes ☐ No

G. PENSION BENEFITS:

I ☐ am ☐ am not, receiving a pension annuity, or retired pay from the United States Government. (If Yes, please furnish source and claim number below.) **Type of Payment:**

☐ Civil Service/FERS/FERS RAE/Furt RAE: Claim Number _____ Retirement Date _____
☐ Alternative Form of Annuity (AA) Lump Sum
☐ Military Retiree's Pay-Branch of Service _____ Rank _____ Retirement Date _____
☐ Veteran's Benefit: Combat Related ☐ Yes ☐ No
☐ Social Security ☐ Foreign Service ☐ CIA ☐ DC Police or Firefighter's Benefit ☐ Other _____

H. CERTIFICATION:

I certify, under penalty of law, that the information provided above is correct and complete.

This document requires a Wet signature.

Signature (Required for appointment) Date

SKIP THIS SECTION

Print ALL pages

Print required and optional pages, NO instructions