

# New Pastors

## Forms to be returned to The Administrative Services Office

Fax: 478-738-9768  
Email: [eleonor@sgaumc.com](mailto:eleonor@sgaumc.com)  
Mail: 3040 Riverside Dr Suite A-2  
Macon, GA 31210

Due: June 17

- Biographical Information**
- Contribution Election Form**  
Clergy serving 1/4 and 1/2-time will be enrolled in UMPIP (employer contributions). Full-time and 3/4-time clergy will be enrolled in CRSP and CPP. All will be automatically enrolled in UMPIP for personal contributions (before- and after-tax contributions are available). Participation with a minimum of 1% of plan compensation (salary + housing) is required to receive the full match provided by the church for the church sponsored plan (CRSP or UMPIP). Amounts must agree with compensation form---Monthly desired contribution X 12. **This form must be completed even if choosing not to participate. If you do not complete this form (to participate or waive), you will be automatically enrolled at 1% - before-tax.**
- (FULL-TIME ONLY) -HealthFlex New Enrollment or Change Form-** Complete Parts 1, 3, 4 - The MRA, HSA and DCA amount entered will be billed in equal payments for remainder of year so enter the amount for 6 months, not an annual amount. Read Parts 5 & 6 and sign on Part 6. Detailed information can be found on our website:

<http://www.sgaumc.org/healthflexhealthinsurance>

The HealthFlex exchange offers you a choice of 6 medical plans, 3 dental plans and also 3 vision plans. Medical coverage is mandatory in our conference; however, you may choose the plan that best suits your needs. The default plan is the C2000 with HRA and is funded by the local church for you (pastor only-not family).

Defined contribution amount for pastor to "shop" with	\$1,153/month
Default plan-C2000 with HRA	\$1,153/month
Spouse <u>or</u> one child-default plan	\$ 880/month
Family (spouse and children)-default plan	\$1,586/month

Medical Reimbursement Account limit (FSA-MRA)	\$3200/annually
Dependent Care Account* limit (FSA-DCA)	\$5000/annually

\*Dependent care is for child care or day program for adult dependent not a spousal MRA

Health Savings Account personal contribution limit (HSA)	Varies by plan
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(over)

- Beneficiary Designation Form*
- Move Expense Reimbursement Amount*

**Send signed forms to District Office AND Administrative Services Office**

Due:  
June 17

- Compensation Form-* A new compensation form must be completed in annual amounts and have signed. Your compensation form is located on your church's dashboard.
- Housing Allowance Resolution-* You must print it out and have it signed by the chairs of both the Administrative Board and the Finance Committee.

**Government Personnel Forms**

**Give these 3 forms to church treasurer/payroll person**

Due: Prior to July 1  
1<sup>st</sup> paycheck

- Form I-9 Employment Eligibility Verification & List of Acceptable Documents* (required as proof of identity and employment authorization). Instructions are located at [www.uscis.gov/i-9](http://www.uscis.gov/i-9).
- Form G-4 State of Georgia Employee's Withholding Allowance Certificate*
- Form W-4 Employees's Withholding Allowance Certificate*

**Fax this form to 404-525-2983 or 888-541-0521**

Due:  
July 10

- Georgia New Hire Reporting Form*

# Biographical Information

Name \_\_\_\_\_

First

Middle

Last

Mailing address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Birthdate \_\_\_\_\_

Social Security # \_\_\_\_\_

Gender Male \_\_\_\_\_ Female \_\_\_\_\_

Spouse Name \_\_\_\_\_

First

Middle

Last

Spouse Birthday \_\_\_\_\_

Spouse SS# \_\_\_\_\_

Marriage Date \_\_\_\_\_

Is Spouse UM Clergy? Yes \_\_\_\_\_ No \_\_\_\_\_

## Dependent Info:

First Middle Last Date of birth SS# Relationship

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Contribution Election—Information and Instructions

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### Personal Investment Plan (PIP)

#### INFORMATION

This form allows you to elect to make before-tax, Roth and/or after-tax contributions to your Personal Investment Plan (PIP)<sup>1</sup> account.

PIP is a 403(b) plan, subject to contribution limits under the Internal Revenue Code. Your total before-tax and Roth contributions for the year to PIP (and any other qualified retirement plans) cannot exceed the lesser of your compensation or the 2024 limit of:

- \$23,000 if you are under age 50 with less than 15 years of service
- \$30,500 (includes \$7,500 “catch-up” contribution) if you will be 50 or older by December 31
- Possibly higher if you have at least 15 years of service within your denomination—call Wespath for further information

Your total before-tax, Roth and after-tax contributions (but not including “catch-up” contributions), plus any plan sponsor contributions to PIP [and any other 403(b) plans sponsored by your plan sponsor] cannot exceed your compensation for the 2024 plan year or \$69,000, whichever is less.

For these limit purposes, compensation does not include the value of any parsonage or housing allowance that is excluded from your taxable income.

You cannot withdraw contributions from PIP unless you have a financial hardship as defined under PIP, attain age 59½, are disabled as defined under PIP, retire, terminate employment and/or you are a clergy person and terminate your relationship with your denomination.

#### INSTRUCTIONS

##### Part 1 – Personal Information

Complete the PDF version of this form electronically or use a black pen and print clearly in CAPITAL LETTERS. If you enter a new address that should be used to update your participant record, ensure that you also update your account information at [benefitsaccess.org](https://benefitsaccess.org), or contact Wespath at 1-800-851-2201.

##### Part 2 – Before-Tax Contribution

Indicate the dollar amount or percentage that you elect to have withheld from your compensation as a before-tax contribution and contributed to PIP.

Your compensation (including the value of any parsonage or housing allowance) will be reduced before withholding taxes are calculated. When you receive distributions from PIP, your before-tax contributions and earnings will be taxable.

##### *Automatic Enrollment*

If your plan sponsor has adopted automatic enrollment, review the **Automatic Enrollment Notice** to determine if this feature applies to you. If you have been automatically enrolled in PIP and wish to change your before-tax contribution election, or if you are about to be automatically enrolled and wish to make a before-tax contribution election that is different than the automatic contribution rate described in the **Automatic Enrollment Notice**, indicate that election on the form.

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<sup>1</sup> References to PIP throughout this document include the United Methodist Personal Investment Plan (UMPIP).

### *Automatic Contribution Escalation*

If your plan sponsor has elected automatic contribution escalation, review the **Automatic Enrollment Notice** to determine your eligibility for this feature and learn how it works. Check the box to indicate whether you elect to have automatic contribution escalation apply to your before-tax contributions. If you do not make an election and are eligible for automatic contribution escalation, this feature will be applied to your contributions as the default election.

### **Part 3 – Roth Contribution**

Indicate the dollar amount or percentage that you elect to have withheld from your compensation as a Roth contribution and contributed to PIP.

Your compensation (including the value of any parsonage or housing allowance) will be reduced after withholding taxes are calculated. When you receive distributions from PIP, your qualified Roth contributions are non-taxable. See the *Roth Contribution Guide* at [wespath.org/roth](http://wespath.org/roth) for more information about the tax implications of Roth account distributions.

### **Part 4 – After-Tax Contribution**

Indicate the dollar amount or percentage that you elect to have withheld from your compensation as an after-tax contribution and contributed to PIP. Note that in most cases a Roth contribution will be more beneficial for a participant than an after-tax contribution. See the *Roth Contribution Guide* at [wespath.org/roth](http://wespath.org/roth) for more information.

Your compensation (including the value of any parsonage or housing allowance) will be reduced after withholding taxes are calculated. When you receive distributions from PIP, your after-tax contributions are non-taxable but the earnings on those contributions are taxable.

### **Part 5 – Signature**

Read the statement and, if you agree, sign and date the form. Then, return it to your employer or plan sponsor. Keep a copy of the submitted form for your records.

### **Part 6 – Acceptance by the Plan Sponsor/Salary-Paying Unit**

Your plan sponsor or salary-paying unit representative must sign and date this form and return it to Wespath as indicated. If you are the plan sponsor representative responsible for retirement benefits, you must have another authorized plan sponsor representative sign and date this form.

## Contribution Election

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### Personal Investment Plan (PIP)

#### Part 1 – Personal Information

Name \_\_\_\_\_ Social Security # (last 5 digits) \_\_\_\_\_

Mailing address \_\_\_\_\_ Primary phone # (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ E-mail \_\_\_\_\_

Clergy       Lay       Bishop

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#### Part 2 – Before-Tax Contribution

Review the Instructions for important information about automatic enrollment and automatic contribution escalation.

Choose one:

- Percentage of compensation:** \_\_\_\_\_% of compensation
- Dollar amount:** \$\_\_\_\_\_ per month (cannot exceed your monthly compensation)
- I elect **not** to make before-tax contributions (*Skip to Part 3*)

#### Automatic Contribution Escalation

Choose one if this feature applies to you—see Instructions:

- I elect to have automatic contribution escalation apply to my before-tax contributions (default)
  - I elect **not** to have automatic contribution escalation apply to my before-tax contributions
- 

#### Part 3 – Roth Contribution

Choose one:

- Percentage of compensation:** \_\_\_\_\_% of compensation
  - Dollar amount:** \$\_\_\_\_\_ per month (cannot exceed your monthly compensation)
  - I elect **not** to make Roth contributions (default)
- 

#### Part 4 – After-Tax Contribution

Choose one:

- Percentage of compensation:** \_\_\_\_\_% of compensation
- Dollar amount:** \$\_\_\_\_\_ per month (cannot exceed your monthly compensation)
- I elect **not** to make after-tax contributions (default)

**Part 5 – Participant Signature**

I have read the instructions, and understand and accept the actions I have taken with this Contribution Election. I acknowledge that:

- The indicated before-tax, Roth and/or after-tax contributions will be withheld from my pay and contributed to my PIP account.
- If my plan sponsor has elected automatic contribution escalation and I am eligible for the escalation, my before-tax contribution percentage will increase each year up to a maximum percentage as specified in the **Automatic Enrollment Notice**, unless I elected not to have automatic contribution escalation apply to my before-tax contributions in Part 2.
- I cannot withdraw contributions from PIP unless I have a financial hardship as defined under PIP, attain age 59 ½, am disabled as defined under PIP, retire, terminate employment and/or am a clergy person and terminate my relationship with my denomination.
- This agreement will remain in effect with my current plan sponsor/salary-paying unit until I submit a new form.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Part 6 – Acceptance by the Plan Sponsor/Salary-Paying Unit**

Authorized representatives completing the form for themselves must have another authorized representative or clergy complete Part 6.

Effective date of this contribution \_\_\_\_\_ 1, 20 \_\_\_\_.

*This date must be the first day of a month on or after the participant signed this form.*

Plan sponsor name \_\_\_\_\_

Employer # \_\_\_\_\_

Plan sponsor address \_\_\_\_\_

Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Authorized representative \_\_\_\_\_

Title \_\_\_\_\_

Authorized signature \_\_\_\_\_

Date \_\_\_\_\_

If you are **NOT** completing this document online, please complete it and return to Wespath by one of the following methods:

- E-mail (scanned copy) to [customersolutionsteam@wespath.org](mailto:customersolutionsteam@wespath.org) or
- Fax to **1-847-866-5195** or
- Mail to Wespath Benefits and Investments  
Customer Solutions  
1901 Chestnut Avenue, Glenview, IL 60025

The plan sponsor/salary-paying unit should keep the original form for its payroll records.  
Be sure to keep a copy for your records.

This form includes and/or is requesting personally identifiable information (PII) and/or protected health information (PHI). You are encouraged to make elections and beneficiary designations online at [benefitsaccess.org](http://benefitsaccess.org). When possible, managing your benefits online is the recommended approach to keep your PII and PHI safe and secure.

Choose one:  New Enrollment  Existing Enrollment

**HealthFlex New Enrollment or Change Form for 2024**

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New hires and newly eligible participants must provide complete information on each eligible dependent. Enrolled participants making changes should provide only the information that has changed.

**Part 1 – Participant/Plan Sponsor Information**

Participant name \_\_\_\_\_ Participant # \_\_\_\_\_  
First Middle Last

Mailing address \_\_\_\_\_ Social Security # \_\_\_\_\_  
(Last 5 numbers unless new enrollment)

\_\_\_\_\_ Primary phone # \_\_\_\_\_

E-mail address \_\_\_\_\_ Alternate phone # \_\_\_\_\_

Marital status:  Single  Married  Divorced  Widowed  Domestic Partnership<sup>1</sup> Effective date of marital status \_\_\_\_\_

Conference/Plan Sponsor/Employer	Employer #	Date of Hire	Appointment/ Employment Status	Status Effective Date	Last Day Worked	Weekly Hours



**Part 2 – Processing Event**

Please check the processing event below.

Event effective date \_\_\_\_\_

Life Status Event	Event Name	Life Status Event	Event Name
New Enrollment	<input type="checkbox"/> New hire <input type="checkbox"/> Newly eligible <input type="checkbox"/> New dependent <input type="checkbox"/> Divorce <input type="checkbox"/> Spousal death <input type="checkbox"/> Spouse loses other coverage	Death	<input type="checkbox"/> Participant death <input type="checkbox"/> Retiree death <input type="checkbox"/> Dependent death
		Termination	<input type="checkbox"/> Declines coverage <input type="checkbox"/> Non-payment <input type="checkbox"/> Participant losing eligibility
Add Dependent for Covered Participants	<input type="checkbox"/> Dependent loses other coverage <input type="checkbox"/> New dependent	Other	<input type="checkbox"/> Annual election <input type="checkbox"/> Conference transfer <input type="checkbox"/> Continuation <input type="checkbox"/> Divorced spouse/legal decree <input type="checkbox"/> New Retiree <input type="checkbox"/> Regaining eligibility/same plan year <input type="checkbox"/> Retiree to active <input type="checkbox"/> No longer eligible for Medicare Secondary Payer Small Employer Exception (MSPSEE) <input type="checkbox"/> Other
Delete Dependent for Covered Participants	<input type="checkbox"/> Dependent child ineligible <input type="checkbox"/> Dependent gains other coverage <input type="checkbox"/> Divorce		

Please list any special notes regarding the event:

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**Part 3 – Participant and Dependent Information**

- List participant **and** all eligible dependents, including spouse<sup>1</sup>, even if declining coverage. If participant is currently enrolled and adding/removing a dependent, list only that dependent’s information.
- Indicate whether or not each individual will be covered. **Important:** If you do not choose “yes” or “no” under the **Cover** column for each dependent listed, we will assume you **do not** want to cover that dependent(s) in HealthFlex.
- Use **Part 8** to provide information on additional dependents.

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover						
				F	M	Yes	No	Medical		Dental		Vision		
								Yes	No	Yes	No	Yes	No	
First Middle Last														
First Middle Last														
First Middle Last														
First Middle Last														
First Middle Last														

## Part 4 – Elections (Active Employees and Pre-65 Retirees<sup>2</sup>)

Medical/Pharmacy	Vision	Dental (if applicable)
<input type="checkbox"/> B1000	<input type="checkbox"/> Vision Exam Core	<input type="checkbox"/> Dental PPO
<input type="checkbox"/> C2000 with HRA	<input type="checkbox"/> Vision Full Service	<input type="checkbox"/> Dental Passive PPO 2000
<input type="checkbox"/> C3000 with HRA	<input type="checkbox"/> Vision Premier	<input type="checkbox"/> DHMO
<input type="checkbox"/> H2000 with HSA	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> H2500 with HSA		
<input type="checkbox"/> H5000 with HSA		
<input type="checkbox"/> None*		

### Notes:

- If no boxes are checked, any individuals who are covered in Part 3 will be enrolled in the default plans.
- Pharmacy, Exam Core vision (unless waived) and behavioral health coverage is included with every medical election.
- None\*—If waiving HealthFlex coverage, Plan Sponsor must complete a *HealthFlex Mandatory Coverage Waiver Form*.

- Health Care Flexible Spending Account (FSA) (if applicable) \$\_\_\_\_\_ (prorated annual amount<sup>4</sup>)
- Dependent Care FSA (if applicable) \$\_\_\_\_\_ (prorated annual amount<sup>4</sup>)
- Health Savings Account (HSA) personal contribution (if applicable/eligible) \$\_\_\_\_\_ (prorated annual amount<sup>3</sup>)

- To enroll into a HSA and to receive the HSA plan sponsor contribution and/or make personal contributions to the HSA, participant must attest to the following:
  - I have read, understand, and accept the eligibility rules of a Health Savings Account (HSA) and I confirm that I am eligible for an HSA.
  - I have read, understand, and accept the HealthEquity Terms of Use, the Card Holder Agreement and Custodial Agreement.

- To decline the HSA, participant must check the statement below:

- Although I have elected an HSA Plan, I elect to waive the HSA. By waiving the HSA, I acknowledge that I will not receive the HSA plan sponsor contribution and I will not be able to make personal contributions into an HSA.

### Regulatory Mailing Preference Election

If you agree to delivery of annual health plan legal and regulatory notices (i.e., notices that explain certain rights and requirements under Medicare Part D, Medicaid/Children’s Health Insurance Program, Women’s Health and Cancer Rights Act, and the HIPAA Notice of Privacy Practices) by email from Wespeth, please note that you have the right to request and receive a paper copy at no cost. You can request a paper copy by contacting the Wespeth Active Benefits Team at 1-800-851-2201 or emailing at [activeteam@wespeth.org](mailto:activeteam@wespeth.org). Your election to receive these notices by email will remain in place unless you withdraw it. You may withdraw your consent to receive notices electronically at any time by contacting the Wespeth Active Benefits Team. If you withdraw this consent, notices will be sent to you via U.S. mail. You may also update your email address at any time with Wespeth by updating your information in Benefits Access or contacting Wespeth. If we receive notification a notice could not be delivered electronically (i.e., email was undeliverable), Wespeth will mail the notice to the address we have on file for you. Additionally, we will opt you out of electronic delivery for regulatory notices. You can elect to receive notices electronically again at any time by contacting the Wespeth Active Benefits Team or during Annual Election.

- I elect to receive regulatory mailings by email
- I elect to receive regulatory mailings by US mail

## Part 5 – Declination of Coverage Information for Participants

If you are declining to cover yourself or any eligible dependents, it is important you understand certain plan rules. By declining coverage, you are declining coverage for the balance of the current plan year, and all subsequent plan years unless you enroll for such coverage during a subsequent annual election period for coverage commencing on the following January 1. Also, any persons for whom coverage is being declined will be subject to late entrant provisions under the plans. In certain circumstances, you may be able to enroll for coverage for yourself or eligible dependents prior to a subsequent annual election period. These circumstances include marriage, birth, adoption or legal guardianship, or loss of other health insurance as provided under the Health Insurance Portability and Accountability Act of 1996 and change of status rules under HealthFlex.

Please make sure to check with your Plan Sponsor regarding the consequences and rules for declining health coverage as a retired participant.

**Part 6 – Participant Signature**

I attest that the participant information is true to the best of my knowledge. In addition, if I am an active participant, I have received, read and I understand the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Special Enrollment and Change of Status Event Provisions and the HealthFlex Notice of Privacy Practices, which are included in my New-Hire Enrollment Kit.

If I am unenrolling in HealthFlex coverage to enroll in a health plan through the Affordable Care Act Marketplace/Exchange, I attest that the individuals I have unenrolled have or will enroll in such health plan effective no later than the day immediately following the last day of HealthFlex coverage.

***If I am declining coverage, I hereby acknowledge I read, understand and accept the rules listed in Part 5 of this form.***

If I am an actively employed participant, I authorize my Salary-Paying Unit to make the appropriate pre-tax payroll deductions from my wages to apply toward my HealthFlex required contributions, if applicable.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

**Part 7 – Plan Sponsor Authorization**

Plan sponsor signature \_\_\_\_\_ Date \_\_\_\_\_

**Part 8 – Additional Dependents**

Name	Social Security #	Birth Date	Relationship	Gender		Disabled		Cover							
				F	M	Yes	No	Medical		Dental		Vision			
								Yes	No	Yes	No	Yes	No		
First Middle Last															
First Middle Last															
First Middle Last															
First Middle Last															
First Middle Last															

**Note:** You can access a *Summary of Benefits and Coverage (SBC)*, which summarizes important information about any health coverage option offered by your plan sponsor. The SBC is available at [benefitsaccess.org](http://benefitsaccess.org); log in and select the **Health** tab across the top, then select **Plan Details** to access the Benefitsolver website. You may need to complete a registration step the first time you use the link. Under the **Reference Center**, select **Summary of Benefits and Coverage (SBC)**. A paper copy is also available, free of charge, by calling **1-800-851-2201**.

- <sup>1</sup> This applies to same-sex civil union partners or legal domestic partners of lay employees in states that have established civil unions or comprehensive state domestic partnerships if the plan sponsor has elected to provide such coverage through Exhibit D to its adoption agreement.
- <sup>2</sup> Pre-65 retirees are not eligible to contribute to a Health Care FSA and/or Dependent Care FSA. In addition, they cannot make personal pre-tax contributions to a Health Savings Account.
- <sup>3</sup> This amount does not include the HSA plan sponsor contribution or any excess defined contribution that will be added to the HSA. Please keep this in mind to avoid exceeding the HSA Annual Contribution Limit established by the Internal Revenue Service (IRS).
- <sup>4</sup> This amount cannot be less than what you have contributed to date through HealthFlex. In addition, this amount will be prorated and billed based on the number of months remaining in the plan year.

If you are **NOT** completing this document online, please complete it and return to Wespath by one of the following methods:

- E-mail (scanned copy) to [healthteam@wespath.org](mailto:healthteam@wespath.org) or
- Fax to **1-847-866-5195** or
- Mail to Wespath Benefits and Investments  
Customer Solutions  
1901 Chestnut Avenue, Glenview, IL 60025

Be sure to keep a copy for your records.

This form includes and/or is requesting personally identifiable information (PII) and/or protected health information (PHI). You are encouraged to make elections and beneficiary designations online at [benefitsaccess.org](http://benefitsaccess.org). When possible, managing your benefits online is the recommended approach to keep your PII and PHI safe and secure.

## Beneficiary Designation—Information and Instructions

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### INFORMATION

This form allows you to choose one or more beneficiaries for the Wespath-administered retirement and welfare plans indicated below. A beneficiary receives plan benefits, if any, after you die or if you cannot be located when a benefit is payable.

A beneficiary can be a person, an organization (religious, educational, charitable, etc.), a trust or another legal entity. More than one beneficiary may share benefits. Your spouse is your primary beneficiary if you are married at the time of your death, unless your spouse has provided written consent for another beneficiary.

Beneficiaries may receive:

- Any amount remaining in a plan account,
- Any monthly payments due under a term-certain annuity or life-and-term-certain annuity, if the participant dies before the end of the term-certain, or
- Death or survivor benefits under certain welfare plans

Beneficiary designations may apply to the following plans:

- Personal Investment Plan (PIP)
- Clergy Retirement Security Program Defined Contribution plan (CRSP DC)
- Ministerial Pension Plan (MPP)
- Pre-1982 Plan (Pre-82)
- Retirement Plan for General Agencies (RPGA)
- Horizon 401(k) Plan (Horizon)
- Comprehensive Protection Plan (CPP)
- Collins Pension Plan for Missionaries (Collins)

Check your beneficiary designations periodically (e.g., each birthday or after a life event like marriage, birth of a child or divorce), and make adjustments as needed. If Wespath cannot locate a beneficiary, that beneficiary will not be able to collect any benefits due.

Your beneficiary designation regarding Wespath-administered plans is binding and supersedes the provisions of your will, your divorce decree or your other wishes.

A beneficiary is not the same as a contingent annuitant. A contingent annuitant is an individual who you elect to receive monthly defined benefits (DB) or annuity benefits upon your death when you apply for these benefits (e.g., MPP, CRSP DB, Pre-82 and Collins monthly benefits). Contingent annuitants cannot be changed.

Beneficiary designations made using this form apply to all Wespath-administered plans listed above. To designate beneficiaries for specific plans, complete your designations online. To designate beneficiaries for LifeOptions contact Unum Life Insurance Company at **1-800-985-0242**. For more information regarding beneficiary designations, visit <https://www.wespath.org/retirement-investments/access-manage-your-benefits/designate-a-beneficiary>.

This designation will apply to all accounts you have as a participant, surviving spouse and/or alternate payee.

## INSTRUCTIONS

You are encouraged to manage your beneficiaries online. To add or change beneficiaries, or to update beneficiaries' personal information, login to [benefitsaccess.org](https://benefitsaccess.org) and from the **Retirement Details** page, select **"Accounts"** and then select **"Beneficiaries."** **If you are unable to update your beneficiaries online, complete this PDF form electronically or use a black pen and print clearly in CAPITAL LETTERS.**

### Part 1 – Personal Information

Complete your personal information.

### Part 2 – Marital Status

Indicate whether you are single or married. If you are married, provide your marriage date, spouse's name, Social Security number and birth date. If you are changing your beneficiary due to divorce, submit a photocopy of your Divorce Decree or similar court order, if you have not already done so.

### Part 3 – Primary Beneficiary(ies)

Enter the personal information for the individual(s) you choose as your primary beneficiary(ies).

If one or more primary beneficiaries is living and can be located at the time of your death, he/she/they will receive 100% of eligible benefits, depending on spousal consent, if applicable.

Wespath-administered plans generally require your surviving spouse to be your sole beneficiary—even if you have submitted a form naming other beneficiaries—unless your spouse has consented to other beneficiaries in Part 5 of this form. Spousal consent is not required for designations relating to accounts you have as a surviving spouse or alternate payee.

If a trust is being named as a beneficiary, a good format to use is:

***John Smith, not personally, but as trustee of the Mary Smith Trust (under an agreement dated Month/Day/Year).***

If an estate is being named as a beneficiary, a good format to use is:

***The estate of John Smith.***

If you need more space, complete your beneficiary designations online or print an additional copy of the form, then sign and date both copies.

### Part 4 – Secondary Beneficiary(ies)

Enter the personal information for the individual(s) you choose as your secondary beneficiary(ies).

Secondary beneficiaries, if any, are eligible to receive your benefits only when all of your primary beneficiary(ies) die(s) before you or cannot be located.

If you need more space, complete your beneficiary designations online or print an additional copy of the form, then sign and date both copies.

### Part 5 – Spousal Consent

Your spouse will be your primary beneficiary if you are married at the time of your death, unless he or she has consented otherwise on this form (or you have named other individuals and have received benefits as an alternate payee or beneficiary of a participant who has died). Your spouse can consent to your designation of other beneficiaries named in Part 3 by completing this section of the document.

Your spouse must consent to the statements that appear on the form, and sign the form in the presence of a Notary Public. Spousal consent is not valid without notarization.

Individuals who are acountholders as a result of divorce or inheriting benefits (i.e., as an alternate payee or beneficiary, including surviving spouses) do not need spousal consent when naming someone other than a spouse.

### Part 6 – Signature

Read the statement and, if you agree, sign and date the form. Then, mail it to Wespath at the address indicated. Keep a copy of the submitted form for your records.

Wespath will send a confirmation once this form is processed. You should review the confirmation and keep it for your records.

## Beneficiary Designation

You are encouraged to manage your beneficiaries online at [benefitsaccess.org](http://benefitsaccess.org). Log in and from the **Retirement Details** page, select **"Accounts"** and then select **"Beneficiaries."** If you are unable to update your beneficiaries online, complete this PDF form electronically or use a black pen and print clearly in CAPITAL LETTERS.

### Part 1 – Personal Information

Name \_\_\_\_\_ Social Security # (last 5 digits) \_\_\_\_\_  
 Mailing address \_\_\_\_\_ Birth date \_\_\_\_\_  
 \_\_\_\_\_ Primary phone # (\_\_\_\_\_) \_\_\_\_\_  
 Country of citizenship \_\_\_\_\_ E-mail \_\_\_\_\_

### Part 2 – Marital Status

Marital status:  Single  Married; date \_\_\_\_\_ Spouse Social Security # \_\_\_\_\_  
 Spouse name \_\_\_\_\_ Spouse birth date \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE INITIAL

If you are submitting this form due to divorce, please submit a photocopy of your *Divorce Decree* or similar court order, if you have not already done so.

### Part 3 – Primary Beneficiary(ies)

For additional primary beneficiaries, see instructions and check here: <input type="checkbox"/>	Social Security #	Date of Birth	Relationship*	Percentage**
Name _____ Address _____ _____				
Name _____ Address _____ _____				
Name _____ Address _____ _____				
Name _____ Address _____ _____				
Name _____ Address _____ _____				

\* Specify "spouse," "child," "legal dependent," "estate," "trust," "organization" or "other."

\*\* Percentages must total 100%.

**Part 4 – Secondary Beneficiary(ies)**

For additional primary beneficiaries, see instructions and check here: <input type="checkbox"/>	Social Security #	Date of Birth	Relationship*	Percentage**
Name _____ Address _____ _____				
Name _____ Address _____ _____				
Name _____ Address _____ _____				
Name _____ Address _____ _____				

\* Specify "spouse," "child," "legal dependent," "estate," "trust," "organization" or "other."  
 \*\* Percentages must total 100%.

**Part 5 – Spousal Consent.** Generally required if married and spouse is not named as the sole beneficiary in Part 3 (see instructions). This section must be notarized. **This form must be returned by mail if spousal consent is required.**

I consent to the specific beneficiary(ies) named on this form. (If your spouse later changes the beneficiary(ies), your consent will be revoked.) I understand that: 1) if I do not sign here, I will receive my spouse’s death benefits, if any, if I am married to my spouse at his or her death; 2) by signing here, I consent to the beneficiary(ies) named in this form; and 3) the effect of this consent is to cause any benefits payable upon my spouse’s death to be paid to those beneficiary(ies) as designated on this form.

Spouse signature \_\_\_\_\_ Date \_\_\_\_\_

Signed in the presence of \_\_\_\_\_

Notary Public signature \_\_\_\_\_

Subscribed and sworn before me on this \_\_\_\_\_

My commission expires \_\_\_\_\_

NOTARY SEAL

**Part 6 – Signature**

I have read the instructions and understand that:

- I designate the person(s) and/or entity(ies) named on this form as my beneficiary(ies) for Wespeth-administered plans.
- I reserve the right to revoke the designation(s) at any time by submitting a new beneficiary designation form with spousal consent, if required.
- Information provided here shall replace and supersede all previous beneficiary designation(s) I have made.
- I understand that naming or changing my beneficiary does *not* affect any contingent annuitant elections I have made or will make.

Print name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

If you are **NOT** completing this document online, please complete it and return to Wespeth by one of the following methods:

- E-mail (scanned copy) to [actveteam@wespath.org](mailto:actveteam@wespath.org),
- Fax to **1-847-866-5195**, or
- Mail to: Wespeth Benefits and Investments  
 Attention: Active Benefits Team  
 1901 Chestnut Avenue, Glenview, IL 60025-1604

Be sure to keep a copy for your records.

This form includes and/or is requesting personally identifiable information (PII) and/or protected health information (PHI). You are encouraged to make elections and beneficiary designations online at [benefitsaccess.org](http://benefitsaccess.org). When possible, managing your benefits online is the recommended approach to keep your PII and PHI safe and secure.

## Move Expense Reimbursement Amount

Pastor's Name: \_\_\_\_\_

Church Name: \_\_\_\_\_

2024 Moving Expenses were paid by the church.

Amount \$ \_\_\_\_\_ (include on pastor's W-2)

No moving expenses paid for pastor's move.

Signature of pastor \_\_\_\_\_

Signature of treasurer \_\_\_\_\_

Return to:

Fax: 478-738-9768

Email: [eleanor@sgaumcadmin.com](mailto:eleanor@sgaumcadmin.com)

Mail: Administrative Services  
P O Box 7227  
Macon, GA 31209





# Employment Eligibility Verification

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

USCIS  
Form I-9

OMB No. 1615-0047

Expires 07/31/2026

**START HERE:** Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

**ANTI-DISCRIMINATION NOTICE:** All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

**Section 1. Employee Information and Attestation:** Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)				
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State ZIP Code			
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number			
<b>I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.</b>	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):								
	<input type="checkbox"/> 1. A citizen of the United States								
	<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)								
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)								
	<input type="checkbox"/> 4. A noncitizen (other than <b>Item Numbers 2.</b> and <b>3.</b> above) authorized to work until (exp. date, if any)								
If you check <b>Item Number 4.</b> , enter one of these:									
USCIS A-Number		OR		Form I-94 Admission Number		OR		Foreign Passport Number and Country of Issuance	
Signature of Employee					Today's Date (mm/dd/yyyy)				

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the Preparer and/or Translator Certification on Page 3.

**Section 2. Employer Review and Verification:** Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)		Additional Information			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.			
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

<b>Certification:</b> I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):	
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative			Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

## LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

\* Documents extended by the issuing authority are considered unexpired.

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

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

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
<ol style="list-style-type: none"> <li>1. U.S. Passport or U.S. Passport Card</li> <li>2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)</li> <li>3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa</li> <li>4. Employment Authorization Document that contains a photograph (Form I-766)</li> <li>5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole:                             <ol style="list-style-type: none"> <li>a. Foreign passport; and</li> <li>b. Form I-94 or Form I-94A that has the following:                                     <ol style="list-style-type: none"> <li>(1) The same name as the passport; and</li> <li>(2) An endorsement of the individual's status or parole 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.</li> </ol> </li> </ol> </li> <li>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</li> </ol>	OR	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. School ID card with a photograph</li> <li>4. Voter's registration card</li> <li>5. U.S. Military card or draft record</li> <li>6. Military dependent's ID card</li> <li>7. U.S. Coast Guard Merchant Mariner Card</li> <li>8. Native American tribal document</li> <li>9. Driver's license issued by a Canadian government authority</li> <li style="text-align: center;"><b>For persons under age 18 who are unable to present a document listed above:</b></li> <li>10. School record or report card</li> <li>11. Clinic, doctor, or hospital record</li> <li>12. Day-care or nursery school record</li> </ol>	AND	<ol style="list-style-type: none"> <li>1. A Social Security Account Number card, unless the card includes one of the following restrictions:                             <ol style="list-style-type: none"> <li>(1) NOT VALID FOR EMPLOYMENT</li> <li>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION</li> <li>(3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION</li> </ol> </li> <li>2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)</li> <li>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</li> <li>4. Native American tribal document</li> <li>5. U.S. Citizen ID Card (Form I-197)</li> <li>6. Identification Card for Use of Resident Citizen in the United States (Form I-179)</li> <li>7. Employment authorization document issued by the Department of Homeland Security                             <p style="margin-left: 20px;">For examples, see <a href="#">Section 7</a> and <a href="#">Section 13</a> of the M-274 on <a href="http://uscis.gov/i-9-central">uscis.gov/i-9-central</a>.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, <b>Item Number 4</b>, document, not a List C document.</p> </li> </ol>

### Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.

For receipt validity dates, see the M-274.

<ul style="list-style-type: none"> <li>• Receipt for a replacement of a lost, stolen, or damaged List A document.</li> <li>• Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual.</li> <li>• Form I-94 with "RE" notation or refugee stamp issued to a refugee.</li> </ul>	OR	<p>Receipt for a replacement of a lost, stolen, or damaged List B document.</p>	<p>Receipt for a replacement of a lost, stolen, or damaged List C document.</p>
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\*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



# Supplement A, Preparer and/or Translator Certification for Section 1

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

**USCIS**  
**Form I-9**  
**Supplement A**  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) from Section 1.	Middle initial (if any) from Section 1.
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**Instructions:** This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code

**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		Date ( <i>mm/dd/yyyy</i> )	
Last Name ( <i>Family Name</i> )	First Name ( <i>Given Name</i> )		Middle Initial ( <i>if any</i> )
Address ( <i>Street Number and Name</i> )	City or Town	State	ZIP Code



# Supplement B, Reverification and Rehire (formerly Section 3)

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

USCIS  
**Form I-9**  
**Supplement B**  
OMB No. 1615-0047  
Expires 07/31/2026

Last Name ( <i>Family Name</i> ) from Section 1.	First Name ( <i>Given Name</i> ) from Section 1.	Middle initial (if any) from Section 1.
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**Instructions:** This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

<b>Date of Rehire (<i>if applicable</i>)</b>	<b>New Name (<i>if applicable</i>)</b>		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
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Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

<b>Date of Rehire (<i>if applicable</i>)</b>	<b>New Name (<i>if applicable</i>)</b>		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
---	--	------------------------------------

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.

<b>Date of Rehire (<i>if applicable</i>)</b>	<b>New Name (<i>if applicable</i>)</b>		
Date ( <i>mm/dd/yyyy</i> )	Last Name (Family Name)	First Name (Given Name)	Middle Initial

**Reverification:** If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

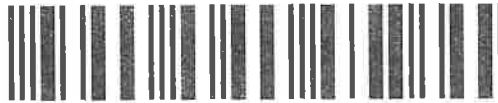
Document Title	Document Number (if any)	Expiration Date (if any) ( <i>mm/dd/yyyy</i> )
----------------	--------------------------	--

**I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.**

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date ( <i>mm/dd/yyyy</i> )
---	--	------------------------------------

Additional Information (Initial and date each notation.)

Check here if you used an alternative procedure authorized by DHS to examine documents.



2411004014

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME 1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route) 2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 - 8

3. MARITAL STATUS

Enter letter below on Line 7.

- A. Single
B. Married Filing Separate or Married Filing Joint, both spouses working
C. Married Filing Joint, one spouse working
D. Head of Household

4. DEPENDENT ALLOWANCES [ ]

5. GEORGIA ADJUSTMENTS ALLOWANCE [ ]
(See instructions for details. Worksheet below must be completed)

6. ADDITIONAL WITHHOLDING \$ \_\_\_\_\_

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed for step 5)

A. Federal Estimated Itemized Deductions (If Itemizing Deductions)..... \$ \_\_\_\_\_
B. Georgia Standard Deduction (enter one):
Single/Head of Household .....\$12,000
Married Filing Joint .....\$24,000
Married Filing Separate .....\$12,000
C. Subtract Line B from Line A (If zero or less, enter zero) .....\$ \_\_\_\_\_
D. Allowable Georgia Adjustments to Federal Adjusted Gross Income .....\$ \_\_\_\_\_
E. Add the Amounts on Lines C and D .....\$ \_\_\_\_\_
F. Estimate of Taxable Income not Subject to Withholding .....\$ \_\_\_\_\_
G. Subtract Line F from Line E (if zero or less, stop here).....\$ \_\_\_\_\_
H. Divide the Amount on Line G by \$3,000. Enter total here and on Line 5 above.....
(This is the number of Georgia Adjustments Allowances you can claim. If the remainder is over \$1,500 round up)

7. LETTER USED (Marital Status A, B, C or D) \_\_\_\_\_ TOTAL ALLOWANCES (Total of Lines 4 - 5) \_\_\_\_\_
(Employer: The letter indicates the tax tables in Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 4 - 7 if claiming exempt) Read the Line 8 instructions on page 2 before completing this section.

- a) I claim exemption from withholding because I incurred no Georgia income tax liability last year and I do not expect to have a Georgia income tax liability this year. Check here [ ]
b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as provided on page 2. My state of residence is \_\_\_\_\_. My spouse's (servicemember) state of residence is \_\_\_\_\_. The states of residence must be the same to be exempt. Check here [ ]

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding. If necessary, mail form to: Georgia Department of Revenue, Taxpayer Services Division, P.O. Box 105499, Atlanta, GA 30359

9. EMPLOYER'S NAME AND ADDRESS: EMPLOYER'S FEIN: \_\_\_\_\_

EMPLOYER'S WH#: \_\_\_\_\_

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 4 - 7.

**INSTRUCTIONS FOR COMPLETING FORM G-4**

Enter your full name, address and social security number in boxes 1a through 2b.

Line 3: Write the letter on Line 7 according to your marital status.

- A. Single
- B. Married Filing Separate or Married Filing Joint, both spouses working
- C. Married Filing Joint, one spouse working
- D. Head of Household

Line 4: Enter the number of dependent allowances you are entitled to claim. The term "dependent" shall have the same meaning as in the Internal Revenue Code of 1986; provided, however, that any unborn child with a detectable human heartbeat, as such terms are defined in Code Section 1-2-1, shall qualify as a dependent minor.

Line 5: Complete the worksheet on Form G-4 if you claim Georgia adjustments Allowances. Enter the number from Line H here.  
**Failure to complete and submit the worksheet will result in automatic denial on your claim.**

Line 6: Enter a specific dollar amount that you authorize your employer to withhold in addition to the tax withheld based on your marital status and number of allowances.

Line 7: Enter the letter of your marital status from Line 3. Enter total of the numbers on Lines 4-5.

Line 8:

- a) Check the first box if you qualify to claim exempt from withholding. You can claim exempt if you filed a Georgia income tax return last year and the amount of Line 4 of Form 500EZ or Line 16 of Form 500 was zero, **and** you expect to file a Georgia tax return this year and will not have a tax liability. You cannot claim exempt if you did not file a Georgia income tax return for the previous tax year. **Receiving a refund in the previous tax year does not qualify you to claim exempt.**

**EXAMPLES:** Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$100. Your tax liability is the amount on Line 4 (or Line 16); therefore, you **do not qualify** to claim exempt.

Your employer withheld \$500 of Georgia income tax from your wages. The amount on Line 4 of Form 500EZ (or Line 16 of Form 500) was \$0 (zero). Your tax liability is the amount on Line 4 (or Line 16) and you filed a prior year income tax return; therefore you **qualify** to claim exempt.

- b) Check the second box if you are not subject to Georgia withholding and meet the conditions set forth under the Servicemembers Civil Relief Act. Under the Act, a spouse of a servicemember may be exempt from Georgia income tax on income from services performed in Georgia if:
  1. The servicemember is present in Georgia in compliance with military orders;
  2. The spouse is in Georgia solely to be with the servicemember;
  3. The servicemember maintains domicile in another state; and
  4. The domicile of the spouse is the same as the domicile of the servicemember or the spouse of the servicemember has elected to use the same residence for purposes of taxation as the servicemember.

Additional information for employers regarding the Military Spouses Residency Relief Act:

1. On the W-2 the employer should not report any of the wages as Georgia wages.
2. If the spouse of a servicemember is entitled to the protection of the Military Spouses Residency Relief Act in another state and files a withholding exemption form in such other state, the spouse is required to submit a Georgia Form G-4 so that withholding will occur as is required by Georgia Law when a Georgia domiciliary works in another state and withholding is not required by such other state. If the spouse does not fill out the form, the employer shall withhold Georgia income tax as if the spouse is single with zero allowances.

**Worksheet for calculating additional allowances.** Enter the information as requested by each line. For Line D, enter items such as Retirement Income Exclusion, U.S. Obligations, and other allowable deductions per Georgia Law, see the IT-511 booklet for more information.

**Do not complete Lines 4-7 if claiming exempt.**

**O.C.G.A. § 48-7-102** requires you to complete and submit Form G-4 to your employer in order to have tax withheld from your wages. By correctly completing this form, you can adjust the amount of tax withheld to meet your tax liability. Failure to submit a properly completed Form G-4 will result in your employer withholding tax as though you are single with zero allowances.

Employers are required to mail any Form G-4 claiming more than 14 allowances or exempt from withholding to the Georgia Department of Revenue. Employers should honor the properly completed form as submitted unless otherwise notified by the Department. Such forms remain in effect until changed or until February 15 of the following year. Employers who know that a G-4 is erroneous should not honor the form and should withhold as if the employee is single claiming zero allowances until a corrected form has been received.

# Employee's Withholding Certificate

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.  
 Give Form W-4 to your employer.  
 Your withholding is subject to review by the IRS.

**2024**

<b>Step 1:</b> <b>Enter Personal Information</b>	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to <a href="http://www.ssa.gov">www.ssa.gov</a> .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2-4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App).

**Step 2:**  
**Multiple Jobs or Spouse Works**

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.  
 Do **only one** of the following.

(a) Use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) for most accurate withholding for this step (and Steps 3-4). If you or your spouse have self-employment income, use this option; **or**

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **or**

(c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate

Complete Steps 3-4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3-4(b) on the Form W-4 for the highest paying job.)

<b>Step 3:</b> <b>Claim Dependent and Other Credits</b>	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 . . . . . \$ _____		
	Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here . . . . .	<b>3</b>	\$ _____
	<b>Step 4 (optional): Other Adjustments</b>	(a) <b>Other income (not from jobs).</b> If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income . . . . .	<b>4(a)</b>
	(b) <b>Deductions.</b> If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here . . . . .	<b>4(b)</b>	\$ _____
	(c) <b>Extra withholding.</b> Enter any additional tax you want withheld each pay period . . . . .	<b>4(c)</b>	\$ _____

**Step 5:**  
**Sign Here**

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

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

\_\_\_\_\_  
**Date**

<b>Employers Only</b>	Employer's name and address	First date of employment	Employer identification number (EIN)



## General Instructions

Section references are to the Internal Revenue Code.

### Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to [www.irs.gov/FormW4](http://www.irs.gov/FormW4).

### Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

**Exemption from withholding.** You may claim exemption from withholding for 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 and you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2024 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2025.

**Your privacy.** Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

**When to use the estimator.** Consider using the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) if you:

1. Expect to work only part of the year;
2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or
3. Prefer the most accurate withholding for multiple job situations.

**Self-employment.** Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at [www.irs.gov/W4App](http://www.irs.gov/W4App) to figure the amount to have withheld.

**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

**Step 1(c).** Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

**Step 2.** Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option (a) most accurately calculates the additional tax you need to have withheld, while option (b) does so with a little less accuracy.

Instead, if you (and your spouse) have a total of only two jobs, you may check the box in option (c). The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



**Multiple jobs.** Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

**Step 3.** This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

### Step 4 (optional).

**Step 4(a).** Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

**Step 4(b).** Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2024 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

**Step 4(c).** Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.



Step 2(b) – Multiple Jobs Worksheet (Keep for your records.)



If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on only ONE Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs. If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, skip to line 3. 1 \$
2 Three jobs. If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
a Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a. 2a \$
b Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b. 2b \$
c Add the amounts from lines 2a and 2b and enter the result on line 2c. 2c \$
3 Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. 3
4 Divide the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in Step 4(c) of Form W-4 for the highest paying job (along with any other additional amount you want withheld). 4 \$

Step 4(b) – Deductions Worksheet (Keep for your records.)



- 1 Enter an estimate of your 2024 itemized deductions (from Schedule A (Form 1040)). Such deductions may 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. 1 \$
2 Enter: { \$29,200 if you're married filing jointly or a qualifying surviving spouse; \$21,900 if you're head of household; \$14,600 if you're single or married filing separately } 2 \$
3 If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-". 3 \$
4 Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information. 4 \$
5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4. 5 \$

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 with no other entries on the form; 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 territories for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

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

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

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

**Married Filing Jointly or Qualifying Surviving Spouse**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$0	\$780	\$850	\$940	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,370
\$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
\$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
\$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
\$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
\$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
\$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
\$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
\$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
\$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
\$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
\$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
\$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
\$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
\$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
\$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
\$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

**Single or Married Filing Separately**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$240	\$870	\$1,020	\$1,020	\$1,020	\$1,540	\$1,870	\$1,870	\$1,870	\$1,870	\$1,910	\$2,040
\$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
\$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
\$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
\$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
\$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
\$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
\$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
\$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
\$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
\$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
\$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
\$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
\$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

**Head of Household**

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$510	\$850	\$1,020	\$1,020	\$1,020	\$1,020	\$1,220	\$1,870	\$1,870	\$1,870	\$1,960
\$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
\$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
\$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
\$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
\$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
\$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
\$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
\$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
\$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
\$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
\$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
\$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
\$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

