



Connecticut State
Colleges & Universities

Human Resources Department
PERSONNEL DATA INFORMATION

Before we can process you on the payroll, the State in accordance with the Board of Regents College Personnel Policies, requires that you complete the following forms and return them to the HR office before your start date. Payment for your services cannot be processed until these documents are received.

Student Packet Requirements
Federal W-4 / CT W-4
Verification of Employment
Proper Identification (2) In Person
Receipt of State Policies
Copy of GCC Course Schedule
I-20 (International Students)

For HR Use Only
College: _____
Employee ID: _____ Record #: _____
Position #: _____
Date of Hire: _____
Net ID#: @ _____
Email: _____
Direct Deposit: Yes No
EE Type: Student Laborer
 Notetaker Work Study

EMPLOYEE INFORMATION:

SOCIAL SECURITY # _____ **DATE OF BIRTH:** _____

NAME: _____
Last Name First Name MI

ADDRESS: _____
Street, Apt. # City, State Zip Code

PHONE: _____
Home Cell Personal e-mail address

EMERGENCY CONTACT: _____
Name Relationship Phone #

TRANSCRIPTS ARE REQUIRED. PLEASE PROVIDE US WITH ANY PREVIOUS NAMES THAT THEY MIGHT BE UNDER: _____

STATE OF CONNECTICUT EMPLOYMENT HISTORY:

New Employee Current Employee Previous Employee Retired State Employee

Current Agency: Where: _____

Previous Agency: Where: _____ Dates: _____

Retired State Employee: Where: _____ Date: _____

Check here if you currently have direct deposit setup with another state agency.

In order to meet Federal and State Affirmative Action/Equal Opportunity reporting requirements, it is necessary that the following information be provided:

GENDER: Female Male Other **VETERAN:** Yes No

ETHNICITY: American Indian African American Caucasian Asian Hispanic Other

US CITIZEN: Yes No

MILITARY SERVICE: Yes No **DATES:** _____

EMPLOYEE SIGNATURE: _____ **Date:** _____

Form CT-W4

Employee's Withholding Certificate

Complete this form in blue or black ink only.

Effective January 1, 2021

Employee Instructions

- Read the instructions on Page 2 before completing this form.
- Select the filing status you expect to report on your Connecticut income tax return. See instructions.
- Choose the statement that best describes your gross income.
- Enter the *Withholding Code* on Line 1 below.

Married Filing Jointly	Withholding Code
Our expected combined annual gross income is less than or equal to \$24,000 or I am claiming exemption under the Military Spouses Residency Relief Act (MSRRA)* and no withholding is necessary.	E
My spouse is employed and our expected combined annual gross income is greater than \$24,000 and less than or equal to \$100,500. See <i>Certain Married Individuals</i> , Page 2.	A
My spouse is not employed and our expected combined annual gross income is greater than \$24,000.	C
My spouse is employed and our expected combined annual gross income is greater than \$100,500.	D
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D
Qualifying Widow(er)	Withholding Code
My expected annual gross income is less than or equal to \$24,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	E
My expected annual gross income is greater than \$24,000.	C
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

Married Filing Separately	Withholding Code
My expected annual gross income is less than or equal to \$12,000 or I am claiming exemption under the MSRRA* and no withholding is necessary.	E
My expected annual gross income is greater than \$12,000.	A
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D
Single	Withholding Code
My expected annual gross income is less than or equal to \$15,000 and no withholding is necessary.	E
My expected annual gross income is greater than \$15,000.	F
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D
Head of Household	Withholding Code
My expected annual gross income is less than or equal to \$19,000 and no withholding is necessary.	E
My expected annual gross income is greater than \$19,000.	B
I have significant nonwage income and wish to avoid having too little tax withheld.	D
I am a nonresident of Connecticut with substantial other income.	D

* If you are claiming the Military Spouses Residency Relief Act (MSRRA) exemption, see instructions on Page 2.

Employees: See *Employee General Instructions* on Page 2. Sign and return Form CT-W4 to your employer. Keep a copy for your records.

1. Withholding Code: Enter *Withholding Code* letter chosen from above. 1. _____
2. Additional withholding amount per pay period: If any, see instructions. 2. \$ _____
3. Reduced withholding amount per pay period: If any, see instructions. 3. \$ _____

Check if you are claiming the MSRRA exemption and enter state of legal residence/domicile: _____

First name	MI	Last name	Social Security Number
Home address (number and street, apartment number, suite number, PO Box)			
City/town	State	ZIP code	

Declaration: I declare under penalty of law that I have examined this certificate and, to the best of my knowledge and belief, it is true, complete, and correct. I understand the penalty for reporting false information is a fine of not more than \$5,000, imprisonment for not more than five years, or both.

Employee's signature	Date
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Employers: See *Employer Instructions*, on Page 2.

Is this a new or rehired employee? No Yes Enter date hired: _____
mm/dd/yyyy

Employer's business name	Federal Employer Identification Number
Employer's business address	
City/town	State ZIP code
Contact person	Telephone number - -

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.**

2021

Step 1: Enter Personal Information	(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 www.ssa.gov .
	City or town, state, and ZIP code _____		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <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, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2: Multiple Jobs or Spouse Works

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

Do **only one** of the following.

(a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3-4); or

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; 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 accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶

TIP: To be accurate, submit a 2021 Form W-4 for all other jobs. If you (or your spouse) have self-employment income, including as an independent contractor, use the estimator.

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

Step 3: Claim Dependents	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 and enter the total here	3	\$ _____
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$ _____
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$ _____
	(c) Extra withholding. Enter any additional tax you want withheld each pay period	4(c)	\$ _____

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	▶ _____ ▶		▶ _____ ▶
	Employee's signature (This form is not valid unless you sign it.)		Date

Employers Only	Employer's name and address _____	First date of employment _____	Employer identification number (EIN) _____
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Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

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

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

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

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

Last Name (Family Name)		First Name (Given Name)		Middle Initial	Other Last Names Used (if any)	
Address (Street Number and Name)			Apt. Number	City or Town		State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 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. <i>(See instructions)</i>	
<p><i>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.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

Signature of Preparer or Translator		Today's Date (mm/dd/yyyy)	
Last Name (Family Name)		First Name (Given Name)	
Address (Street Number and Name)		City or Town	State ZIP Code

Employer Completes Next Page



Employment Eligibility Verification
Department of Homeland Security
U.S. Citizenship and Immigration Services

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

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
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

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

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

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

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

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

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

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

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

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

Refer to the instructions for more information about acceptable receipts.

Thank you for deciding to enroll in the State of Connecticut's Direct Deposit system. You will save yourself a lot of time and effort by having the money electronically distributed into your bank account.

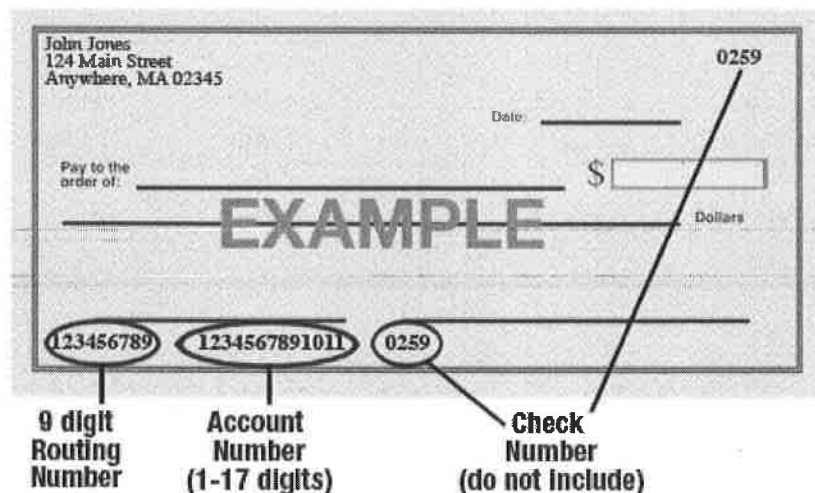
To help insure that your Direct Deposit enrollment is a smooth one please note the following items:

- Your first/second check (depending on when form is submitted) after handing in your direct deposit will still be a "live" check.
- Your bank account should indicate one, "\$.01" deposits from the State of Connecticut on the first available check date after you have submitted your form. This is a dry run which helps insure that money will correctly go into your account.
- Following this dry run the rest of your paychecks will go into this account unless you fill out another direct deposit form either changing or canceling your account number.

IMPORTANT- You must notify the payroll office BEFORE closing your bank account, to ensure that your monies are deposited into the correct account.

Please note

- If you need to change this request it must be submitted 4 weeks in advance to ensure the correct change.
- Direct Deposit usually takes effect by the third check



In order to access your pay check information you must log onto CORE using the following procedure:

Open a browser and go to: <http://www.core-ct.state.ct.us>. Click on Login, Enter User ID and Password. **User ID** is your state Employee ID which is found on your paystub. This is not your NET ID but a six number ID issued by the state's payroll system. **Default Password** is first four letters of last name (UPPER CASE) and last four numbers of your social security number. ** if last name less than four letters, use entire last name only** Under My System Profile: a. Click on "Change or set up forgotten password help" Click OK and continue to "Primary Email Address". Add your email address.

To view paychecks- Click on "View Paycheck Information" under the Payroll menu

DIRECT DEPOSIT AUTHORIZATION AND INPUT FORM

CO-1040 REV. 06/08

STATE OF CONNECTICUT
 OFFICE OF THE COMPTROLLER
 PAYROLL SERVICES DIVISION
 55 ELM STREET
 HARTFORD, CONNECTICUT 06106

INSTRUCTIONS: Please read carefully prior to completing this application. For processing State Employee Net Pay associated with State Employment..

SECTION I

EMPLOYEE INFORMATION

DEPT ID	EMPLOYEE NUMBER	EMPLOYEE NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>

TYPE OF ACTION

New
 Change
 Delete Account # _____
 Other _____

Add Additional Account
COMPLETE SECTION I and III ONLY

ACCOUNT # 1

SECTION II

This section must be completed for first time Direct Deposit enrollees or if an employee is changing or deleting a prior account. If an employee is adding an additional account, please check off the "Add Additional Account ONLY" box in Section I, and complete Section III.

DIRECT DEPOSIT ACCOUNT INFORMATION
FINANCIAL INSTITUTION NAME

ACCOUNT NUMBER

ROUTING TRANSIT NUMBER

ACCT TYPE

<input type="text"/>	<input type="text"/>
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PLEASE NOTE:

Please see section III for Additional Account Requirements

C = Checking
 S = Savings

COMPLETE THIS SECTION TO ADD AN ADDITIONAL ACCOUNT ONLY

ACCOUNT # 2 (Additional Account)

SECTION III

Additional Account Requirements:

Employee must have one existing account that has successfully completed the pre-note process in order to add an additional account. New employees or employees who are signing up for direct deposit for the first time are not permitted to sign-up for an additional account until Account #1 has successfully completed the pre-note process.

Flat Amount Option for Account # 2 \$ _____
 Please note that the remainder of Net Pay will be deposited into Account #1 under the Flat Amount Option

Percentage Split Option for Account #1 and Account #2
 Must be equal to 100% (e.g. 50% Account #1 and 50% Account #2, 40% Account #1 and 60% Account 2, etc.)

_____ % Percentage of Net Pay to be deposited into Account #1

_____ % Percentage of Net Pay to be deposited into Account # 2

DIRECT DEPOSIT ACCOUNT INFORMATION
FINANCIAL INSTITUTION NAME

ACCOUNT NUMBER

ROUTING TRANSIT NUMBER

ACCT TYPE

<input type="text"/>	<input type="text"/>
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C = Checking
 S = Savings

AGREEMENT

PLEASE READ THE FOLLOWING CAREFULLY

I HEREBY AUTHORIZE THE STATE OF CONNECTICUT ("STATE") TO ELECTRONICALLY DEPOSIT MY NET SALARY TO THE BANK ACCOUNT(S) NAMED ABOVE. THIS AUTHORIZATION IS TO REMAIN IN FORCE UNTIL THE STATE HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND MANNER AS TO AFFORD THE STATE, AND THE BANK(S) NAMED ABOVE, A REASONABLE OPPORTUNITY TO ACT UPON IT. IN THE EVENT THAT THE STATE NOTIFIES THE BANK(S) THAT FUNDS WHICH I DID NOT EARN HAVE BEEN DEPOSITED TO MY ACCOUNT (S) IN ERROR, I HEREBY AUTHORIZE AND DIRECT THE BANK(S) TO RETURN SAID FUNDS TO THE STATE AS SOON AS POSSIBLE. IN THE EVENT SUCH UNEARNED FUNDS HAVE BEEN DRAWN FROM THE ACCOUNT(S) SO THAT RETURN OF THOSE FUNDS BY THE BANK(S) TO THE STATE IS NOT POSSIBLE, I HEREBY AUTHORIZE THE STATE TO RECOVER THOSE FUNDS BY DEDUCTING THE AMOUNT OF SAID UNEARNED FUNDS FROM ANY FUTURE SALARY PAYMENTS FROM THE STATE UNTIL THE AMOUNT OF THE UNEARNED DEPOSIT(S) HAS BEEN RECOVERED IN FULL. IN THE EVENT MY EMPLOYMENT WITH THE STATE IS TERMINATED FOR ANY REASON WHATSOEVER, AND IF AT THE TIME OF SUCH TERMINATION I HAVE HAD UNEARNED PAY AUTOMATICALLY DEPOSITED IN MY CHECKING/SAVINGS ACCOUNT(S), I WILL IMMEDIATELY REPAY THE STATE THE FULL AMOUNT OF SUCH UNEARNED PAY. I FURTHER AGREE THAT IF I DO NOT IMMEDIATELY REPAY SUCH UNEARNED PAY, I WILL BE PERSONALLY LIABLE FOR ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY'S FEES INCURRED BY THE STATE IN THE COLLECTION OF SUCH UNEARNED PAY, TOGETHER WITH THE MAXIMUM INTEREST PERMITTED BY LAW.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE AGREEMENT.

SIGNATURE

DATE

POLICY AGAINST SEXUAL HARASSMENT

Implementing Statement

What is Sexual Harassment?

Sexual harassment is a form of sex discrimination, which is illegal under state and federal law and is also prohibited by the Board of Regents Nondiscrimination Policy. The Board's policy recognizes that sexual harassment undermines the integrity of employer-employee and student-faculty-staff relationship and interferes with the right of all members of the College community to work and learn in an environment free from harassment. Such conduct will not be tolerated.

Sexual harassment may be described as:

Any unwelcome sexual advance or request for sexual favors, or any conduct of a sexual nature where (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or education, (2) submission to or rejection of such conduct by an individual is used as a basis for employment or academic decisions affecting the individual, or (3) such conduct has the purpose or effect of substantially interfering with an individual's academic or work performance or creating an intimidating, hostile or offensive employment or educational environment.

Sexual harassment may be verbal, visual or physical. It may be overt or implicit and may, but need not, have tangible adverse effects on the victim's employment or learning experience.

Examples of conduct which may constitute sexual harassment include but are not limited to:

- Sexual flirtation, touching, advances or propositions
- Verbal abuse of a sexual nature
- Pressure to engage in sexual activity
- Graphic or suggestive comments about an individual's dress or appearance
- Use of sexually degrading words to describe an individual
- Display of sexually suggestive objects, pictures or photographs
- Sexual jokes
- Stereotypic comments based upon gender
- Threats, demands or suggestions that retention of one's employment or educational status is contingent upon toleration of or acquiescence in sexual advances.

The perpetrator of sexual harassment, like the victim of such conduct, may be a man or a woman. Sexual harassment may involve individuals of the same or opposite sex and, in the College environment, may involve an employee and a student, an employee and another employee, or a student and another student. Harassment in any of these relationships is a violation of the Board's policy.



**Connecticut State
Colleges & Universities**

ALL NEW HIRES

You will find a copy of the Board Policy against Sexual Harassment, which was recently revised in two respects on our Human Resources website.

- ❖ Romantic/sexual liaisons between a faculty member or a professional staff member and a student for whom that staff member has teaching, advisory or other supervisory responsibility are prohibited.
- ❖ The time frame for filing a student complaint of sexual harassment is extended to 180 days of the date the student knew or should have known of the alleged harassment.

These changes were adopted because relations between faculty members/professional staff members and students, by definition, involve an imbalance in power and can sometimes be abused. Moreover, in the event of a judgment that sexual harassment has occurred, the risk of liability for a college, not to mention the potential exposure for the faculty member/professional staff member is very high. We hope that prohibition of faculty-student and professional staff member-student dating in the circumstances described in the revised policy will serve as an additional deterrent to sexual harassment and thereby protect the institution, its students and its employees.

If you have any questions concerning the application of the described prohibition to your situation, it is recommended that they be resolved in favor of abstaining from a romantic or sexual liaison with a student for whom you have or may have supervisory responsibility. If necessary, you may seek advice from your dean as to whether a particular relationship involves supervisory responsibility.

Thank you in advance for your attention to the system policy and for your cooperation in ensuring that there is no place for sexual harassment within the CSCU system.

Please sign this letter below to indicate that you have received and read this letter and the Policy against Sexual Harassment. Return the signed copy to the Human Resources Office Thank you.

Signature

Print Name

Date



Connecticut State
Colleges & Universities

ETHICS POLICIES

All new hires

State of Connecticut
State Code of Ethics

Acknowledgement

I _____ have been made aware that the State Ethics Commission's Guide to the Code of Ethics for Public Officials and State Employees is located on the Human Resources website. [Ethics Policy](#)

I understand and agree that, as a public employee, working for the CSCU system I must use my best efforts to comply with the standards set forth within the policy.

Employees Signature

Date



NORTHWESTERN CONNECTICUT COMMUNITY COLLEGE POLICES, PROCEDURES AND INFORMATION

All employees must be aware of the policies of the State of Connecticut and Northwestern Connecticut Community College.

Sign and return this form the Human Resources office indicating that **you have been informed of the policies and procedures listed below, and are aware that these and other policies are available in the Human Resources office and on the CSCU/HR website <https://www.ct.edu/hr/policies>**

- Employee Policy & Procedures manual
- Sexual Harassment
- Affirmative Action Policy Statement
- Nepotism in Employment
- Policy on Consensual Relationships
- Policy Regarding Reporting Suspected Abuse or Neglect of a Child
- Ethics Statement – I understand and agree that, as a public employee, I must use my best efforts to comply with the standards set forth within the policy

Other Information

- New Health Insurance Marketplace Coverage Options and Your Health Coverage
- Direct Deposit
- Computer Login Procedures
- CORE-CT Login Procedures

Employee Signature

Date



New Health Insurance Marketplace Coverage Options and Your Health Coverage

INTRODUCTION

The Affordable Care Act requires us to inform all employees about the Health Insurance Marketplaces, which were set up to make it easier for consumers to compare plans and enroll in health insurance coverage. If you are eligible for employee health benefits through the State of Connecticut you will most likely not save money by purchasing coverage through the Marketplace. However, if you are not eligible for job-based health benefits, you may want to consider purchasing coverage through the Marketplace, as explained below.

PART A: General Information

When key parts of the Affordable Care Act take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplaces. In Connecticut, the state Marketplace is known as the Connecticut Health Insurance Exchange ("the Exchange"). You can find out more by visiting <http://www.accesshealthct.com/> or calling 855-805-4325. This notice provides some basic information and explains how coverage available through the Exchange relates to coverage that is available to you as an employee of the State of Connecticut

Q—What is the Health Insurance Marketplace?

It is designed to help you find health insurance that meets your needs and fits your budget. The Exchange offers "one-stop shopping" to find and compare private health insurance options. Some individuals and families may be eligible for a tax credit that lowers their monthly premium right away as well as cost-sharing reductions that can lower their out-of-pocket expenses. Open enrollment for health insurance coverage through the Exchange begins in October 2013 for coverage starting as early as January 1, 2014. You can find out more by visiting <http://www.accesshealthct.com/> or calling 855-805-4325.

Q—Can I qualify for federal assistance that would reduce my health insurance and out-of-pocket expenses?

You may qualify to save money and lower your monthly premium by purchasing coverage through the Exchange, but only if (1) you are not eligible for coverage from your employer or (2) your employer's coverage doesn't meet certain standards.

Q—What are those standards?

If your employer health plan meets a "minimum value standard" and is "affordable" you will not qualify for federal assistance. An employer health plan meets the "minimum value standard" if it covers at least 60 percent of total allowed costs. It is considered "affordable" if the cost of single coverage (not including other family members) is no more than 9.5 % of your annual household income.

Q—Does State of Connecticut employee coverage meet the minimum value standard?

Yes.

Q—What does “affordable” mean?

Coverage is considered “affordable” if the employee’s share of individual-only coverage is no more than 9.5% of household income. For example, the employee share for individual-only coverage for the lowest-cost plan offered by the State of Connecticut is \$39.63 per month, or \$475.56 per year. If you are healthcare-eligible and earn \$5006 or more per year, the cost of coverage would be considered “affordable”.¹

Q—Does Eligibility for Employer Health Coverage Affect Premium Savings through the Marketplace?

Yes, if your job-based health coverage meets the “minimum value standard” and is “affordable” you will not be eligible for either a tax credit or subsidy through the Marketplace and may wish to enroll in your employer health plan.

Q—What happens if I am eligible for employer-based coverage but choose to purchase insurance through the Marketplace?

If you purchase a health plan through the Marketplace instead of accepting your job-based health benefits you will lose the State of Connecticut contribution to your health coverage. Also, the employer contribution—as well as your employee premium share—is excluded from your income for Federal and State income tax purposes. If you purchase insurance coverage through the Exchange your payments for healthcare coverage will be made on an after-tax basis.

Q—How Can I Get More Information?

For more information about coverage offered by your employer, please check the Health Care Options Planner at <http://www.osc.ct.gov/benefits/openenroll.htm> or contact the Office of the State Comptroller, Healthcare Policy & Benefit Services Division, Central Benefits Unit.

The Exchange can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. You can find out more by visiting the CT Exchange at <http://www.accesshealthct.com/> or calling 855-805-4325. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area if you are not a Connecticut resident.

¹ This is an illustration based on annual earnings only. There are other factors that that may affect “affordability”, such as when an employee’s hours vary from week to week or an employee starts working mid-year.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name State of Connecticut, Office of the State Comptroller		4. Employer Identification Number (EIN) 06-6000798	
5. Employer address 55 Elm Street		6. Employer phone number	
7. City Hartford	8. State CT	9. ZIP code 06106	
10. Who can we contact about employee health coverage at this job? Healthcare Policy & Benefit Services Div., Central Benefits Unit			
11. Phone number (if different from above) 860-702-3535		12. Email address osc.benefitcorrections@ct.gov	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees.
 - Some employees. Eligible employees are:
Full-time permanent employees, employees working 0.5 full-time equivalent (FTE), others pursuant to collective bargaining agreement or management contract
- With respect to dependents:
 - We do offer coverage. Eligible dependents are:
Spouse or civil union partner, employee's children to age 26 (medical)
 - We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
 - ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ 39.63

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much will the employee have to pay in premiums for that plan? \$

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

Date of change (mm/dd/yyyy):

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)