



DISTRICT ENROLLMENT FORM

Employee Name		First	Middle	Last
Employee Number	Effective Date	District		

Address	City	State / ZIP	Home Phone No.
Emergency Contact			Contact Phone No.

Social Security No.																								
Federal Withholding Status (attach W-4) <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Married @ Sngl Rate																								
Federal Withholding Exemption(s)																								
Additional Withholding per Pay Period																								
Salary or Hourly Rate _____ per _____																								
Employment Status (hours per month) <input type="checkbox"/> F.T. () <input type="checkbox"/> Temp () <input type="checkbox"/> Seasonal () <input type="checkbox"/> P.T. () <input type="checkbox"/> Intern () <input type="checkbox"/> Other ()																								
Position <input type="checkbox"/> Non-Union <input type="checkbox"/> Union <input type="checkbox"/> Elected																								
Health & Welfare Benefits																								
<table border="0"> <tr> <td>Type of Benefit</td> <td>code</td> <td>Type of Benefit</td> <td>code</td> </tr> <tr> <td>Medical</td> <td>_____</td> <td>Other</td> <td>_____</td> </tr> <tr> <td>Dental</td> <td>_____</td> <td>RETIREMENT</td> <td>_____</td> </tr> <tr> <td>Vision</td> <td>_____</td> <td><input type="checkbox"/> PERS</td> <td>_____</td> </tr> <tr> <td>Life</td> <td>_____</td> <td><input type="checkbox"/> LEOFF</td> <td>_____</td> </tr> <tr> <td>Life Dependant</td> <td>_____</td> <td><input type="checkbox"/> _____</td> <td>_____</td> </tr> </table>	Type of Benefit	code	Type of Benefit	code	Medical	_____	Other	_____	Dental	_____	RETIREMENT	_____	Vision	_____	<input type="checkbox"/> PERS	_____	Life	_____	<input type="checkbox"/> LEOFF	_____	Life Dependant	_____	<input type="checkbox"/> _____	_____
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Home Fund		
Home Cost Center/Department		
Date Started		
Date of Birth		
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
Job Title		
Work Site		
Supervisor		
Employment Security <input type="checkbox"/> Covered (001) <input type="checkbox"/> Not Covered (007)		
Social Security <input type="checkbox"/> Covered <input type="checkbox"/> Not Covered		
Deductions*	Amount Deducted	Effective Date
Dues: <input type="checkbox"/> Initiation	_____ /month	_____
<input type="checkbox"/> Monthly	_____ /month	_____
Deferred Compensation	_____ /pay period	_____
Financial Institution	_____ /pay period	_____
United Way	_____ /pay period	_____
Other _____	_____ /pay period	_____
*Attach Appropriate Forms		

Worker's Comp. codes:

<input type="checkbox"/> 1501 Cemeteries	<input type="checkbox"/> 4904 Fire 3 only	<input type="checkbox"/> 6103 Library - admin./cler.	<input type="checkbox"/> 6904 Firefighters
<input type="checkbox"/> 1507 Water	<input type="checkbox"/> 5306 Clerical	<input type="checkbox"/> 6104 Library - other	<input type="checkbox"/> Other

Comments:

Authorization			
Commissioner	Date	Prepared By	Date
Commissioner	Date	Input By	Date