UCONN
SCHOOL OF MEDICINE

Graduate Medical Education
263 FARMINGTON AVENUE, LM068
FARMINGTON, CT 06030-1921
PHONE: 860.679.2147
FAX: 860.679.4624

Capital Area Health Consortium
270 FARMINGTON AVENUE, SUITE 352
FARMINGTON, CT 06032-1994
PHONE: 860.676.1110
FAX: 860.676.1303

AY 2023-2024

Welcome New Resident/Fellow:

While you are a resident/fellow appointed to the University of Connecticut School of Medicine (UConn SOM) training program, you will be employed by and receive your salary and benefits from Capital Area Health Consortium (the Consortium).

The Consortium will pay your salary and fringe benefits while withholding the necessary tax and employee benefit deductions from your paycheck. We will also provide you with the enrollment forms and plan descriptions for your insurance coverage and other fringe benefits. Please visit our website at Benefits and Payroll | Graduate Medical Education (uconn.edu) for more detailed benefit information.

By signing and returning this Agreement Letter, you agree to abide by the terms contained in the current UConn SOM Resident/Fellow Policy Manual, as amended from time to time online at Resident/Fellow Policy Manual | Graduate Medical Education (uconn.edu).

Please contact the Consortium at (860)-676-1110 if you have any questions or need further information.

Sincerely,

Michelle Nielson

Michelle Nielson
Executive Director
Capital Area Health Consortium

Accepted:

Gaurav Sekhon
Print Name

5-5-2023
Signature Date

Equal Opportunity Employer

# HOUSE STAFF PROFILE SHEET

Name Gaurav Sekhon SSN: 672-33-5310 DOB: 07/05/1991
(first name) (last name/surname) (leave blank if no U.S. social yet) (month/day/year)

Residency Program: UConn CAP Fellowship

Gender: ☐ M ☐ F ☑ Not Specified Marital Status: ☑ S ☐ M

Citizenship: USA_____ Other (Country) Canada

Race (for government reporting only):

☐ Caucasian ☐ Black ☐ Hispanic ☑ Asian/Pacific Islander ☐ Amer Indian/Alaskan Native

**Current/Future CT Address** (leave blank if future address is unknown)

Street:_____

City: _____ State: _____ Zip: _____ Phone: _____

Cell Phone: _____ Personal Email Address: _____

Address Effective as of: _____

**Emergency Contact (U.S. Contact Only)**

Name: Sam Sekhon Relationship: Father

Phone: 917 - 708 - 3967

Form **W-4**

Department of the Treasury
Internal Revenue Service

# 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.**

OMB No. 1545-0074

2023

## Step 1: Enter Personal Information

| (a) First name and middle initial | Last name | (b) Social security number |
|---|---|---|
| Gaurav | Sekhon | |

Address: 199 Second Street, Apartment E420

City or town, state, and ZIP code: Mineola, NY 11501

**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*.

(c)
- ☑ **Single** or **Married filing separately**
- ☐ **Married filing jointly** or **Qualifying surviving spouse**
- ☐ **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, other details, 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)** Reserved for future use.

**(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 . . . . . ☐

**TIP:** If you have self-employment income, see page 2.

**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 Dependent and Other Credits

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 . . . . . **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** 05-05-2023

## Employers Only

| Employer's name and address | First date of employment | Employer identification number (EIN) |
|---|---|---|
| Capital Area Health Consortium<br>270 Farmington Ave, Ste 352<br>Farmington, CT 06032 | | 51-0173264 |

#3

Department of Revenue Services
State of Connecticut
(Rev. 12/22)

# Form CT-W4
## Employee's Withholding Certificate

**Effective January 1, 2023**

**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.
- 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 *Certain Married Individuals*, 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 Surviving Spouse | 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. F
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 |
|---|---|---|---|
| Gaurav | | Sekhon | 672-33-5310 |
| Home address (number and street, apartment number, suite number, PO Box) | | | 199 2nd St. Apt. E420 |
| City/town | State | ZIP code | Mineola, NY 11501 |

**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 |
|---|---|
|  | 05-05-2023 |

**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 |
|---|---|
| Capital Area Health Consortium | 51-0173264 |
| Employer's business address | 270 Farmington Ave, Ste 352 |
| City/town / State / ZIP code | Farmington / CT / 06032 |
| Contact person | Telephone number |
| Michael Tran | 860 – 676 – 1110 |

Visit us at **portal.ct.gov/DRS** for more information.

**#4**

**Submit later if you need U.S. bank account.**

# DIRECT DEPOSIT AUTHORIZATION FORM

**Please Print Clearly**

Name_____
(first name) (m.i.) (last name/surname)

If you wish to deposit into more than one bank account, you must deposit a specific dollar amount or percentage into the Account #1 and the remaining balance will go into Account #2.

**ACCOUNT # 1**

Bank or Credit Union
Name_____

Routing Number 0260-13673 Account Number 4382358187

☑ Checking Account ☐ Savings Account

Full Deposit $_____ Dollar Amount $_____ **OR** Percentage Amount %100

---

**ACCOUNT # 2**

Bank or Credit Union
Name_____

Routing Number _____ Account Number _____

☐ Checking Account ☐ Savings Account

Remainder ☐

---

***A voided check or bank direct deposit form showing the full routing and account number must be included with this form for each account.**

I understand that in the event my financial institution(s) is/are not able to deposit any electronic transfer into my account(s) due to any action I take, I understand that Capital Area Health Consortium cannot reissue funds to me until the funds are returned to them by my financial institution(s). If your account is credited in error, CAHC is authorized to debit my account for the same amount.

This authorization will remain in force until the CAHC is notified in writing to cancel the Direct Deposit.

_____ 05-05-2023
Employee Signature Date

# Life Insurance
# Beneficiary Designated Form



**In the event of death, the listed beneficiary/ies will receive one payment equal to the employee's annual salary up to a maximum of $50,000. In the event of an accidental death, the amount will be three times the annual benefit. A beneficiary must be designated.**

**It is okay to list foreign relatives that do not have U.S. SSN's.**

| Name of employer/group (if applicable) | |
|---|---|
| Capital Area Health Consortium, Inc. | to start 07-01-2023, currentl |
| Employee Name<br>Gaurav Sekhon | Social security no.<br>6 7 2 3 3 5 3 1 0 |

**PRIMARY BENEFICIARY(IES): Person or persons who will receive the life insurance proceeds upon your death.**

| Name | Date of birth | Social security no. | |
|---|---|---|---|
| | 1 2 1 4 1 9 9 6 | | |
| Address | Relationship to insured | % to be paid to beneficiary | |
| 2636 Ruby Court, Victoria, BC, Canada V9B 0A9 | sister | 100 | |
| **Name**<br>Sam Sekhon | Date of birth | Social security no. | |
| Address | Relationship to insured | % to be paid to beneficiary | |
| **Name** | Date of birth | Social security no. | |
| Address | Relationship to insured | % to be paid to beneficiary | |

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, proceeds will be paid to the Contingent beneficiary(ies) listed below. Space is provided at the bottom of the page if you wish to name additional Primary or Contingent beneficiaries.

**CONTINGENT BENEFICIARY(IES): Person or persons who will receive the life insurance proceeds if there is no surviving primary beneficiary.**

| Name | Date of birth | Social security no. | |
|---|---|---|---|
| Manji Sekhon | 0 2 1 4 1 9 6 9 | | |
| Address | Relationship to insured | % to be paid to beneficiary | |
| 2636 Ruby Court, Victoria, BC, Canada V9B 0A9 | | | |
| **Name** | Date of birth | Social security no. | |
| Address | Relationship to insured | % to be paid to beneficiary | |
| **Name** | Date of birth | Social security no. | |
| Address | Relationship to insured | % to be paid to beneficiary | |

| Employee Signature | Date signed (MM/DD/YYYY) |
|---|---|
| **X**  | 0 5 0 5 2 0 2 3 |

## Life Insurance
## Beneficiary Designation Form - continued

THE EMPLOYER **MUST** KEEP THIS FORM ON FILE.

### BENEFICIARY DESIGNATIONS

**DEFINITIONS:**
The purpose of designating beneficiaries for this policy is to instruct exactly how you wish the proceeds of your policy/certificate to be paid upon your death. Therefore, please take a moment to read the examples below:

**PRIMARY BENEFICIARY:**
Person or persons to receive the Life Insurance proceeds upon the death of the Insured. If multiple Primary Beneficiaries are listed, death benefits are divided equally among all the living Primary Beneficiaries, unless otherwise stated.

**CONTINGENT BENEFICIARY:**
Person or persons to receive the Life Insurance proceeds when the Primary Beneficiary(ies) dies before the Insured. If multiple Contingent Beneficiaries are listed, death benefits are divided equally among all the living Contingent Beneficiaries, unless otherwise stated.

**EXAMPLES OF CORRECT BENEFICIARY DESIGNATIONS:**

Joe and Jane Smith – Father and Mother
William E. Brown – Spouse
George Jones – Friend
Donald C. White, Jane E. Smith, and Richard E. Beck – Children

If you choose the estate or a trust as beneficiary, see the following example beneficiary designation:
Insured's Estate: John Q. Smith – trustee under the Mary R. Smith Trust dated 01/02/2006.

Full given names of each beneficiary must be clearly stated.

### ADDITIONAL BENEFICIARY(IES)

#### PRIMARY

| **Name** | Date of birth | Social security no. |
|---|---|---|
| Address | Relationship to insured | % to be paid to beneficiary |
| **Name** | Date of birth | Social security no. |
| Address | Relationship to insured | % to be paid to beneficiary |
| **Name** | Date of birth | Social security no. |
| Address | Relationship to insured | % to be paid to beneficiary |

#### CONTINGENT

| **Name** | Date of birth | Social security no. |
|---|---|---|
| Address | Relationship to insured | % to be paid to beneficiary |
| **Name** | Date of birth | Social security no. |
| Address | Relationship to insured | % to be paid to beneficiary |

# Employment Eligibility Verification

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

**USCIS**
**Form I-9**
OMB No. 1615-0047

**►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)* |
|---|---|---|---|
| Sekhon | Gaurav | | |

| Address *(Street Number and Name)* | Apt. Number | City or Town | State | ZIP Code |
|---|---|---|---|---|
| 199 Second Street | E420 | Mineola | NY | 11501 |

| Date of Birth *(mm/dd/yyyy)* | U.S. Social Security Number | Employee's E-mail Address | Employee's Telephone Number |
|---|---|---|---|
| 07 / 05 / 1991 | 672 - 33 - 5310 | sekhon@uchc.edu | 646 - 283 - 0120 |

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

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

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States *(See instructions)*
- ☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- ☑ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): 06 / 30 / 202
  Some aliens may write "N/A" in the expiration date field. *(See instructions)*

*Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.*

**1.** Alien Registration Number/USCIS Number: _____

**OR**

**2.** Form I-94 Admission Number: 135271180A3

**OR**

**3.** Foreign Passport Number: HN758533

Country of Issuance: Canada

QR Code - Section 1
Do Not Write In This Space

| Signature of Employee | Today's Date *(mm/dd/yyyy)* |
|---|---|
| | |

## 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 |
|---|---|---|---|
| | | | |

STOP *Employer Completes Next Page* STOP

# Employment Eligibility Verification

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

**USCIS**
**Form I-9**
OMB No. 1615-0047

## 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 |
|---|---|---|---|---|
| | | | | USA |

| List A<br>Identity and Employment Authorization | OR | List B<br>Identity | AND | List C<br>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 | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date *(if any) (mm/dd/yyyy)* | | | | |
| Document Title | | | | |
| Issuing Authority | | | | |
| Document Number | | | | |
| Expiration Date *(if any) (mm/dd/yyyy)* | | | | |

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

**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 |
|---|---|---|
| | | Director of Payroll and Benefits |

| Last Name of Employer or Authorized Representative | First Name of Employer or Authorized Representative | Employer's Business or Organization Name |
|---|---|---|
| Tran | Michael | Capital Area Health Consortium |

| Employer's Business or Organization Address (*Street Number and Name*) | City or Town | State | ZIP Code |
|---|---|---|---|
| 270 Farmington Avenue Ste 352 | Farmington | CT | 06032 |

## 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)* |
|---|---|---|
| | | |

**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 |
|---|---|---|
| | | |

## LISTS OF ACCEPTABLE DOCUMENTS
## All documents must be UNEXPIRED

#6 cont.

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<br>Documents that Establish Both Identity and Employment Authorization | OR | LIST B<br>Documents that Establish Identity | AND | LIST C<br>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:<br>(1) NOT VALID FOR EMPLOYMENT<br>(2) VALID FOR WORK ONLY WITH INS AUTHORIZATION<br>(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:<br>**a.** Foreign passport; and<br>**b.** Form I-94 or Form I-94A that has the following:<br>(1) The same name as the passport; and<br>(2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. | | **5.** U.S. Military card or draft record | | **5.** U.S. Citizen ID Card (Form I-197) |
| | | **6.** Military dependent's ID card | | **6.** Identification Card for Use of Resident Citizen in the United States (Form I-179) |
| | | **7.** U.S. Coast Guard Merchant Mariner Card | | **7.** Employment authorization document issued by the Department of Homeland Security |
| | | **8.** Native American tribal document | | |
| | | **9.** Driver's license issued by a Canadian government authority | | |
| | | **For persons under age 18 who are unable to present a document listed above:** | | |
| **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 | | **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.**

#6 cont.

# Capital Area Health Consortium and The University of Connecticut School of Medicine
## International Information Collection Form

This information will allow the Capital Area Health Consortium and The University of Connecticut School of Medicine Graduate Medical Education Office to determine your U.S. residency status for tax purposes and is not associated with immigration or visa classification. All internationals must provide documentation proving valid U.S. status (DS2019, I-94, EAD, Alien Resident Card, passport etc.). If a document expires during training, a new one with valid dates must be provided. If given with the I-9, additional documents are not needed.

PLEASE COMPLETE ALL APPLICABLE QUESTIONS

| A. LAST OR FAMILY NAME | FIRST OR PERSONAL NAME | MIDDLE NAME | B. TRAINING PROGRAM |
|---|---|---|---|
| Sekhon | Gaurav | | CAP fellowship |

| C. COUNTRY OF BIRTH | D. CITY OF BIRTH | E. COUNTRY OF CITIZENSHIP | F. SOCIAL SECURITY NUMBER |
|---|---|---|---|
| Canada | Victoria | Canada | 672-33-5310 |

G. DO YOU HAVE PASSPORTS ISSUED FROM MORE THAN ONE COUNTRY? (circle one) ☐ YES or ☑ NO IF YES, WHAT COUNTRIES?

H. MY CURRENT IMMIGRATION STATUS IS: (mark only one box)

- ☑ J-1 Alien Physician
- ☐ Employment Authorization Document: based on (circle one):
  J-2 Pol. Asy. Adj. of Status Other:_____
  Start Date: _____ End Date: _____
- ☐ Permanent Resident (skip to section O below)

I. ORIGINAL DATE OF ENTRY TO U.S. ON CURRENT VISA STATUS OR EFFECTIVE DATE OF CHANGE OF STATUS FILED IN THE U.S.:

J. PASSPORT NUMBER HN758533

K. PASSPORT EXPIRATION DATE 07 / 10 / 2027

L. VISA NUMBER DS2019

M. HAVE YOU BEEN IN THE U.S. DURING THE PAST 6 YEARS? YES or NO If yes, please complete the information below. If no, skip to section N.

| Visa (e.g. B-1, F-1, B-2, J-1, J-2) | Entry Date | Exit Date | Subtype if Visa was J-1* |
|---|---|---|---|
| 1. J-1 | July 2020 | n/a | Alien Physician |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

*If J-1, subtypes are: Professor, Research Scholar, Trainee, Alien Physician, Short-Term Scholar, or Specialist

N. HAVE YOU PREVIOUSLY BEEN IN YOUR CURRENT VISA OTHER THAN THOSE LISTED ABOVE? ☐ YES or ☑ NO If yes, please give dates.

O. MISCELLANEOUS The following information is needed for immigration reporting purposes only (this does not affect you visa classification/status):

Marital Status
- ☑ Single
- ☐ Married
  Spouse's Name
  _____

Number of dependents in the U.S. 0 Name and birth dates:

1. _____
2. _____
3. _____
4. _____

P. I hereby certify that the information provided above is true and correct and I will provide the required documentation when needed. If my visa/immigration status changes, I will notify the Graduate Medical Education office.

SIGNATURE 05 - 05 - 2023 DATE

OFFICE USE ONLY

- ☐ J-1 and in U.S. for a total of two or fewer of the past 6 calendar years.
- ☐ Substantial Presence Test needed (Total less than 183, nonresident; Equal or greater than 183, resident

| | | Year | Number of Days in U.S. | | Calculation for Substantial Presence Test |
|---|---|---|---|---|---|
| | Current Year | | | X 1 = | |
| | 1st Preceding Year | | | X 1/3 = | |
| | 2nd Preceding Year | | | X 1/6 = | |
| | | | | Total | |

| FICA Status | FICA Status Change Date | Review Date |
|---|---|---|
| | | |

# MEDICAL/DENTAL/VISION EMPLOYEE BENEFIT ACKNOWLEDGMENT

The Capital Area Health Consortium Section 125 Plan of the Internal Revenue Code which enables employees to pay their Medical, Dental and Vision insurance premium contributions on a pre-tax basis. Since these contributions are not subject to Federal, State or FICA taxes, taxable income is reduced. Consequently, Social Security benefits may also be reduced.

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## HEALTH INSURANCE PREMIUM SALARY REDUCTION AGREEMENT

(_✔_) I authorize Capital Area Health Consortium to reduce my salary by the amount necessary to pay the employee insurance premium contributions required to purchase health insurance coverage under the Capital Area Health Consortium's Group Health Insurance Plan. I understand the deductions will be made on a pre-tax basis and that under Section 125 of the Internal Revenue Code, I may not change or cancel pre-tax benefits until the beginning of the next Plan Year, unless I have a Change in Status as defined by IRS rules. I further understand that this form must be signed and dated prior to my Plan effective date to be eligible to participate.

I understand that if I choose to participate in the Plan now or later, my Employer is authorized to make pre-tax contributions to pay for medical, dental, and vision benefit options for myself and, if applicable, my spouse and eligible children plan dependents.

Employee Signature

05 - 05 - 2023

Date

Gaurav Sekhon

Employee Printed Name

**#8**

# COBRA RIGHTS – ACKNOWLEDGMENT OF RECEIPT OF NOTIFICATION

I hereby acknowledge that I have received notification of my COBRA continuation rights to extend my group plan health coverage. I understand that all costs for continuation coverage will be at my own expense, and I must submit a COBRA Continuation Election Form to elect coverage within 60 days of the loss of coverage.

Employee Signature — Date: 05-05-2023

Gaurav Sekhon

Employee Printed Name

**YOUR SPOUSE MUST ALSO SIGN THIS FORM IF ARE MARRIED AND INCLUDING THEM ON THE HEALTH INSURANCE PLAN.**

Spouse Signature — Date

Spouse Printed Name

**Employees and their spouses are responsible for promptly informing CAHC of a divorce, legal separation, or child losing dependent status under the group plan. In addition, employees or family members must keep CAHC informed of their current addresses.**

Anthem



# Enrollment and Membership Change Form #9

## 1. Tell Us About You

| Last Name | First Name | M.I. |
|---|---|---|
| Sekhon | Gaurav | |

Home Address: Number and Street or P.O. Box: 199 Second St. Apt.
Apt. #: E420

| City | State | Zip Code |
|---|---|---|
| Mineola | NY | 11501 |

| Home Telephone | Work Telephone |
|---|---|
| 646 - 283 - 0120 | 646 - 283 - 0120 |

MARITAL STATUS: ☐ SINGLE ☐ LEGALLY SEPARATED ☐ WIDOWED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

## 2. New Membership

- ☑ NEW HIRE
- ☐ OPEN ENROLLMENT
- ☐ COBRA/C G.S. 38a-538

DATE OF QUALIFYING EVENT MM / DD / YR

REASON _____ SEE INSTRUCTION SHEET

## 3. Change Membership

CHANGE
- ☐ ADDRESS
- ☐ NAME

INDICATE FORMER NAME

- ☐ OTHER

REASON

DATE OF QUALIFYING EVENT MM / DD / YR

## To Be Completed By Employer

Requested Effective Date

Firm Division No.
068965M003
068965D003
068965V003

For Office Use On

## 4. Your Membership Choices

| | Individual | Two Person | Family |
|---|---|---|---|
| ☐ CENTURY PREFERRED/PPO | ☑ | ☐ | ☐ |
| ☐ DENTAL | ☑ | ☐ | ☐ |
| ☐ BLUE VIEW VISION | ☑ | ☐ | ☐ |

Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? ☐ YES ☒ NO

## 5. Where You Work

Capital Area Health Consortium
270 Farmington Avenue Suite 352
Farmington CT 06032-1994

ARE YOU ACTIVELY AT WORK? ☐ YES ☐ NO / (IF NO ) REASON ☐ SICK ☐ INJURED ☐ OTHER

ARE YOU CURRENTLY CLAIMING WORKERS COMP. MEDICAL BENEFITS? ☐ YES ☒ NO

DO YOU WORK 30 OR MORE HOURS PER WEEK? ☒ YES ☐ NO

DATE OF FULL TIME HIRE: to start 07-01-2023, currently

DATE OF REHIRE: MM / DD / YR

## 6. List Members To Be Added/Cancelled

| SEX | NAME (LAST NAME/FIRST/M.I.) | Add | Cancel | Social Security Number | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|---|---|
| ☐ M ☑ F | Self: Sekhon, Gaurav | | | 672-33-5310 | 07 / 05 / 91 |
| ☐ M ☐ F | Spouse | | | | MM / DD / YR |

DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.

| | | | | | |
|---|---|---|---|---|---|
| ☐ M ☐ F | Dependent | | | | MM / DD / YR |
| ☐ M ☐ F | Dependent | | | | MM / DD / YR |
| ☐ M ☐ F | Dependent | | | | MM / DD / YR |

## 7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental or Anthem BCBS coverage? ☒ YES ☐ NO

If yes, please fill in the information below. ☐ Self ☐ Spouse ☐ Children

| Name of Company | Name of Subscriber (Policyholder) | Policy or ID No. | Reason for Termination | First and Last Date of Coverage |
|---|---|---|---|---|
| NYSHIP | Blue Cross / Blue Shield | 890965199 | completing residency | 07-01-20 to 06-30-23 |

## 8. Medicare/Medicaid

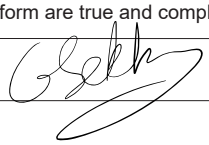
Do you or any other covered member have Medicare/Medicaid coverage? ☐ YES ☒ NO

Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

| Name(s) of Medicare Beneficiaries | Are you actively at work? | Retirement date (MM/DD/YY) | Health insurance claim no. | Medicare Part A effective date | Medicare Part B effective date | Medicare Part D effective date |
|---|---|---|---|---|---|---|
| | ☐ YES ☐ NO | MM / DD / YR | | | | |
| | ☐ YES ☐ NO | MM / DD / YR | | | | |
| | ☐ YES ☐ NO | MM / DD / YR | | | | |

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

## 9. Employee Signature



Date: 05 - 05 - 23

UCONN
SCHOOL OF MEDICINE

Graduate Medical Education
263 FARMINGTON AVENUE, LM068
FARMINGTON, CT 06030-1921
PHONE 860.679.2147
FAX 860.679.4624

Capital Area Health Consortium
270 FARMINGTON AVENUE, SUITE 352
FARMINGTON, CT 06032-1994
PHONE 860.676.1110
FAX 860.676.1303

# MEDICAL/DENTAL/VISION WAIVER

I am declining Medical Insurance at this time ☐

I am declining Dental Insurance at this time* ☐

I am declining Vision Insurance at this time* ☐

_____

Print Name

_____ _____

Employee Signature Date

*If Medical insurance is taken without Dental and Vision Insurance, you will not be able to enroll in the Dental and Vision plan until the next Open Enrollment, which is the month of June with a July 1 effective date.

**NOTICE OF EMPLOYEE RIGHTS UNDER CONNECTICUT FAMILY AND MEDICAL LEAVE ACT (CTFMLA) AND THE CONNECTICUT PAID LEAVE ACT (CTPL) – ACKNOWLEDGMENT**

I hereby acknowledge that I have received notification of my employee rights under the Connecticut Paid Leave Act (CTPL). I understand that Capital Area Health Consortium (CAHC) has been approved for a Private Plan as an alternative to the publicly administered State Program, which provides me the same or greater rights, or benefits than the State Program.

For CAHC to maintain its Private Plan, it must show that a majority of its employees approve the Private Plan via an employee vote.

**ADDITIONAL BENEFITS OFFERED THROUGH CAHC'S PRIVATE PLAN**

- Allows CAHC to offer more significant leave benefits for medical leaves, paying at 100% of pay instead of paying at the reduced State rate of 60 times the Connecticut minimum wage rate while on a health provider approved medical leave. As of 7/1/22, $ 840 weekly and increasing to $900 weekly) on 6/1/23.
- Allows you to earn increased net leave pay by eliminating FICA and FLI tax deductions while on leave.
- Allows you to work directly with CAHC on your leave of absence instead of CT Paid Leave Authority or their Third-Party Administrator.

**PRIVATE PLAN CHOICE:**

"Do you approve Capital Area Health Consortium's private plan to provide benefits required by the CT Paid Family Insurance Act" ☑ Yes ☐ No

Employee Initials Only: