Burkhardt, Scott

From: Burkhardt, Scott
Sent: Tuesday, December 22, 2015 2:46 PM
To: Rana, Linda
Cc: Julian, Colleen; Nie, Judy
Subject: 12-22-15 Arthur Roman 457 Revision (IPPFA)
Attachments: 12-22-15 2015 Payroll Document Inventory - Arthur Roman -- Revise 457 Deduction; 20151222144030

Linda – As attached from $40PP to 3%PP. A copy is in the sleeve.

Tks./S

Scott Burkhardt
City Clerk/Collector
City of Oak Forest
15440 South Central Avenue
Oak Forest, IL 60452
Telephone (708) 444-4810
Fax (708) 535-0014
sburkhardt@oak-forest.org

12/22/2015

Payroll Document Inventory - Full Time

Hire Date 10/27/2014

Employee Name Arthur Roman — **Revise IPPFA 457 Deduction**

Employee Position Police Officer

Today's Date 12/22/2015

Item	*From*	*To*		
Federal W-4				
IL W-4				
Direct Deposit Authorization				
	Plan Choice	**Category**	**Effective Date**	**Cost Per Paycheck**
Health Insurance (24 bi-monthly only)				
Dental Insurance (24 bi monthly only)				
Life Insurance (26 bi-weekly)				
HRA (Benny Card)				
FSA Package (26 bi-weekly)				
Aflac (26 bi-weekly)				
	From	***To***	**Effective Date**	**Cost Per Paycheck**
457 Def. Comp. - AXA (26 bi-w)				
457 Def. Comp. - AIG-VALIC (26 bi-w)				
457 Def. Comp. - ICMA (26 bi-w)				
457 Def. Comp. - IPPFA (26 bi-w)	$40.00/PP Pre-tax	3%/PP Pre-tax	Next Payroll	3%/PP Pre-tax*
Rate Sheet				
Union Dues (24 bi-monthly only)				
VEBA Contribution				

*Estimate PP - $30.14/hr. *80*.03=$72.33

TRANSAMERICA Retirement Solutions
4333 Edgewood Road NE
Cedar Rapids, IA 52499

Section A: Employer Information **Enrollment Application**

Company/Employer Name: City of Oak Forest

☐ New Enrollment
■ Contribution Change

Contract/Account No.: PE61743 Affiliate No.: 00001 Division No.: OKFT

Section B: Participant Information

Social Security No.: [redacted] Date of Birth (MM-DD-YYYY): [redacted]

First Name/Middle Initial: Arthur E Last Name: Roman

Mailing Address: 9306 Walnut Ln State: IL Zip code: 60487

City: Tinley Park E-mail: [redacted]

Phone No./Ext.: [redacted] Date of Hire (MM-DD-YYYY): 10-27-2014

Marital Status: ☐ Married ■ Single/Divorced Gender: ■ Male ☐ Female

Section C: Contributions (By law, any election will not be effective until the following month, except if completed on the first day of employment or earlier.)

☑ 457(b) – I elect to reduce my eligible compensation by 3.00 % or $_____ each pay period as a Pre-tax salary deferral contribution. (Deferral may be up to the maximum allowed by law.)

☐ Roth 457 – I elect to reduce my eligible compensation by _____% or $_____ each pay period as a Roth deferral contribution. (Deferral may be up to the maximum allowed by law.)

Revised

RECEIVED
DEC 21 2015
BY: Scott B.

☐ I elect not to make contributions to this plan.

☐ Contact me to help me consolidate another retirement plan (401K, 403B, IRA, etc) into my new Transamerica account.

Section D: Investment Allocation

1) **One-Step Diversification** - Automatic allocation and reblancing service using all the core funds in your plan.

PortfolioXpress®

☐ Please enroll me in this service. By checking this box **I agree to allocate 100% of my contributions** based on my target retirement year and risk preference:

My target retirement year: 20 44

☐ **I agree** to each of the asset allocation mixes and automated rebalancing transactions that will occur within my account as I approach retirement. I understand that I may turn the service off at any time, or change my designated retirement year and/or risk preference, by signing in to my account at my.trsretire.com or calling Transamerica at 800-755-5801. All future rebalancing transactions are shown on the attached PortfolioXpress Profile, which includes an investment glidepath.

STOP HERE! Do not complete the section below if you have enrolled in PortfolioXpress, which requires a 100% allocation of new contributions to your account. Please go directly to Section E.

2) Create or Choose Your Own Portfolio- Please allocate contributions to the following investment options in the percentages noted below (total must equal 100%):

Choose a Portfolio			Create a Portfolio		
C20B	Short Horizon Asset Allocation	%	CT4B	Money Market Fund	%
C35B	Short/Intermediate Horizon Asset Allocation	%	GDAF	TFLIC Stable Fund	%
C21B	Intermediate Horizon Asset Allocation	%	C15B	High Quality Bond Fund	%
C22B	Intermediate/Long Horizon Asset Allocation	%	CT5B	Core Bond Fund	%
C36B	Long Horizon Asset Allocation	%	C0DC	Inflation-Protected Securities Fund	%
			C26B	High-Yield Bond Fund	%
			CT6B	Large Value	%
			C0AC	Large Core	%
			C0FC	Stock Index Fund	%
			CT1A	Large Growth	%
			C40B	Mid Value	%
			C39B	Mid Growth	%
			C41B	Small Value	%
			C0BC	Small Core	%
			C42B	Small Growth	%
			CRTB	Real Estate Fund	%
			C12B	International Equity Fund	%

Section E: Signatures

If I elected the PortfolioXpress service in Section C (Investment Allocation), I hereby acknowledge that I have received and reviewed the attached PortfolioXpress Disclosure Statement and the PortfolioXpress Profile (which includes the Investment Glidepath for PortfolioXpress). I further understand that I may change the amount of my salary reduction, or terminate this agreement, by giving notice in accordance with the terms of my employer's plan.

Balances in a Schwab Personal Choice Retirement Account are not available for investment in the PortfolioXpress service. Should you choose to maintain these assets in PCRA, you will be restricted from making any additional transfers into PCRA. The assets in your PCRA account will remain, and will not be included in the investment strategy provided through this service. If you choose to liquidate your PCRA account, please contact a Transamerica representative.

I understand that any catch-up contributions elected above are not determined to be catch-up contributions until my regular pre-tax salary deferral contributions exceed an applicable limit under the plan, and that the amount of my salary reduction above may not exceed the limits of contributions set forth in my employer's plan.

Transamerica Investors Securities Corporation (TISC), 440 Mamaroneck Avenue, Harrison, NY 10528, distributes securities products. Any registered fund offered under the plan is distributed by that particular fund's associated fund family and its affiliated broker-dealer or other broker-dealers with effective selling agreements such as TISC.

I acknowledge that investment option information, including prospectuses, disclosure documents, and/or fund profile sheets, as applicable have been made available to me and I understand the risks of investing.

The Transamerica funds are distributed by Transamerica Capital, Inc. (TCI) and are advised by Transamerica Asset Management (TAM). Transamerica, TISC, TAM, and TCI are affiliated companies.I understand that the fixed interest option(s) are available under group annuity contract(s) issued by Transamerica Financial Life Insurance Company ("TFLIC") and that the mutual fund options are subject to a Custodial Agreement with State Street Bank and Trust Company ("SSBT"). I understand that the group annuity contracts are legally separate arrangements from the Custodial Agreement. SSBT has no control over or responsibility for the group annuity contracts. I understand that an annual administrative fee, a withdrawal charge, and transfer restrictions may apply.The Transamerica investment options are available under a group variable annuity contract issued by Transamerica Financial Life insurance Company ("TFLIC"), which is offered through Transamerica Investors Securities Corporation, 440 Mamaroneck Avenue, Harrison, NY 10528. I understand that an annual administrative fee, a withdrawal charge, and transfer restrictions may apply.The Stable Pooled Fund is offered through Diversified Investment Advisors Collective Trust and invests directly in the Wells Fargo Stable Return Fund which is a collective trust fund of Wells Fargo.

I agree to the terms of the plan. I am aware that amounts deferred under this type of plan are included in my employer's general assets. I understand that I may change the amount of my salary reduction, or terminate this agreement, by giving notice according to the terms of the plan. I understand that upon termination of my employment, my account will be distributed according to my election and according to the terms of the plan.

X A. Roman — Participant Signature — 12/18/15 — Date

Plan Administrator — 12-22-15 — Date

TRANSAMERICA® Retirement Solutions
4333 Edgewood Road NE
Cedar Rapids, IA 52499

Section A: Employer Information

Enrollment Application

Company/Employer Name: **The Wise Choice for Public Employees**

☐ New Enrollment
☐ Contribution Change

Contract/Account No.: **PE61743** Affiliate No.: **00001** Division No.: **OKFT**

Section B: Participant Information

Social Security No.: [redacted] Date of Birth (MM-DD-YYYY): [redacted]

First Name/Middle Initial: Arthur E Last Name: Roman

Mailing Address: 9306 Walnut Ln State: IL Zip code: 60487

City: Tinley Park E-mail: [redacted]

Phone No./Ext.: [redacted] Date of Hire (MM-DD-YYYY): 10-27-2014

Marital Status: ☐ Married ☒ Single/Divorced Gender: ☒ Male ☐ Female

Section C: Contributions (By law, any election will not be effective until the following month, except if completed on the first day of employment or earlier.)

☐ I elect to reduce my eligible compensation by _____% (from 1% up to 100% of your pay), each pay period as a pre-tax salary deferral contribution.

☐ I elect to reduce my eligible compensation by _____% (from 1% up to 100% of your pay), each pay period as a Roth salary deferral contribution.

Note: You may apply the age 50 catch-up or the last three taxable years catch-up for any given calendar year.

☐ (For employees who have attained age 50 or will attain age 50 this calendar year) I elect to reduce my eligible compensation, in equal amounts each pay period, as a pre-tax salary deferral catch-up contribution, as indicated below:

☐ Maximum amount each year (contact Transamerica for further information)

☐ As a pre-tax salary deferral contribution.

☐ As a Roth contribution.

Current

☐ $_____ each year as a pre-tax salary deferral contribution.

☐ $_____ each year as a Roth contribution.

☐ I am in the last three taxable years ending before the year of my normal retirement age (as defined in the plan) and have underutilized past contributions while eligible. I elect to make additional contributions in accordance with the Special 457(b) Catch-up provision. The catch-up contribution will not exceed the lesser of my underutilized limit or twice the dollar amount of the 457(b) limit allowed for the year that I elect to contribute the catch-up contribution. I elect to make a catch-up contribution: * $40 / check to 26 Bi-weekly Payroll

☒ as a pretax salary deferral contribution, for the taxable year _____ of $1040 or _____%. (whole percentages)

☐ as a Roth contribution, for the taxable year _____ of $_____ or _____%. (whole percentages)

☐ The above election(s) is effective with the payroll period beginning _____ (may not be retroactive).

CITY OF OAK FOREST
RATE APPROVAL REQUEST

EMPLOYEE: Roman, Arthur
EFF. DATE: 10/27/2015
HIRE DATE: 10/27/2014
DATE ISSUED: 11/17/2015

FROM:						
BASE	45,489.00	YEAR	1,749.58	PAY PERIOD	21.87	HR
EDUCATION/LONGEVITY	-		-		-	
TOTAL	45,489.00	YEAR	1,749.58	PAY PERIOD	21.87	HR
TO:						
BASE	61,260.00	YEAR	2,356.15	PAY PERIOD	29.45	HR
EDUCATION/LONGEVITY	1,440.00		55.38		0.69	
TOTAL	62,700.00	YEAR	2,411.54	PAY PERIOD	30.14	HR

JOB CLASSIFICATION: Police Officer

REASON FOR REQUEST: Step Increase - Step 1 to Step 2 - Educational Incentive

DEPT: Police Department

SUPERVISOR: Gregory Anderson

Burkhardt, Scott

From: Burkhardt, Scott
Sent: Tuesday, November 17, 2015 8:05 AM
To: Burkhardt, Scott
Subject: 11-17-15 Arthur Roman payroll

//718

270 ROMAN, M ARTHUR E
9306 WALNUT LN
TINLEY PARK IL 60487

Telephone 1:
Telephone 2:
Social Security number:

Job class:
Hire date: 10/27/2014
Pay type: Hourly

Quarterly | Monthly | Pay Period | Gross | Leave | Employee | Notes

General | Detail | Attachments

Department:	03 - POLICE	Hourly rate:	21.8697
Job position:	OFFICER	Estimated annual hours:	2,080.0000
Employee status:	Full Time	Annual wage:	45,488.9800
Gender:	Male	Pay schedule:	OFFICER
Direct deposit:		Pay grade:	Education Grade 1
Work site:		Pay step:	Base Pay
Work state:	IL		
WC class:			
SUTA type:	Regular		
FWT calculation:	Single - Federal Withholding		
FWT exemptions:	0		
SWT calculation:	Single - Illinois State Withholding		
SWT exemptions:	0		
EIC calculation:			
Termination date:			

City of Oak Forest | sab | N:\Clarity\Oak Forest Startup

Payroll Document Inventory - Full Time

Hire Date 10/27/2014

Employee Name Arthur Roman — Rate/step Increase; Edu. Incentive

Employee Position Police Officer

Today's Date 10/21/2015

Item	From	To		
Federal W-4				
IL W-4				
Direct Deposit Authorization				
	Plan Choice	**Category**	**Effective Date**	**Cost Per Paycheck**
Health Insurance (24 bi-monthly only)				
Dental Insurance (24 bi monthly only)				
Life Insurance (26 bi-weekly)				
HRA (Benny Card)				
FSA Package (26 bi-weekly)				
Aflac (26 bi-weekly)				
457 Def. Comp. - AXA-EQUITABLE (26 bi-w)				
457 Def. Comp. - AIG-VALIC (26 bi-w)				
457 Def. Comp. - ICMA (26 bi-w)				
457 Def. Comp. - IPPFA (26 bi-w)				
	From	*To*	**Effective Date**	**Cost Per Paycheck**
Rate Sheet	$45,489	$62,700	10/27/2015	As calculated
Union Dues (24 bi-monthly only)				
VEBA Contribution (FD/PD-IPPFA)				
IMRF Submittal				

LEAVE TIME	**Amount**
Vacation	
Holiday Vacation (FD only)	
Floating	
Sick Accrual	

CITY OF OAK FOREST
RATE APPROVAL REQUEST

EMPLOYEE: Arthur Roman	HIRE DATE: 10-27-14
EFFECTIVE DATE: 10-27-15	DATE ISSUED: 10-21-15
From: $45,489	Total Pay: $45.489
To: $61,260 Education Incentive $1,440	Total Pay: $62,700
Pay Per Hour: $30.14	Time & ½ Rate: $45.21
Job Classification: Police Officer	
Reason for Request: Step Raise Education Incentive	Department: Police

Department Head: Chief Gregory Anderson

Budget Officer Approval: _____

Treasurer Approval: _____

Mayoral Approval: _____

Burkhardt, Scott

From: Burkhardt, Scott
Sent: Wednesday, October 21, 2015 11:34 AM
To: Rana, Linda
Cc: Nie, Judy
Subject: 10-21-15 Arthur Roman Step/Edu. Increase (Eff. 10-27-15
Attachments: 20151021112023

L – As attached; copy is in the sleeve.

Tks./S

Scott Burkhardt
City Clerk/Collector
City of Oak Forest
15440 South Central Avenue
Oak Forest, IL 60452
Telephone (708) 444-4810
Fax (708) 535-0014
sburkhardt@oak-forest.org

10/21/2015

Payroll Document Inventory - Full Time

Hire Date 10/27/2014

Employee Name Arthur Roman

Employee Position Police Officer

Today's Date 10/21/2015

Rate/step Increase
Edu. Incentive

2023
10-21-15

Item	From	To		
Federal W-4				
IL W-4				
Direct Deposit Authorization				
	Plan Choice	Category	Effective Date	Cost Per Paycheck
Health Insurance (24 bi-monthly only)				
Dental Insurance (24 bi monthly only)				
Life Insurance (26 bi-weekly)				
HRA (Benny Card)				
FSA Package (26 bi-weekly)				
Aflac (26 bi-weekly)				
457 Def. Comp. - AXA-EQUITABLE (26 bi-w)				
457 Def. Comp. - AIG-VALIC (26 bi-w)				
457 Def. Comp. - ICMA (26 bi-w)				
457 Def. Comp. - IPPFA (26 bi-w)				
	From	To	Effective Date	Cost Per Paycheck
Rate Sheet	$45,489	$62,700	10/27/2015	As calculated
Union Dues (24 bi-monthly only)				
VEBA Contribution (FD/PD-IPPFA)				
IMRF Submittal				

LEAVE TIME	Amount
Vacation	
Holiday-Vacation (FD only)	
Floating	
Sick Accrual	

CITY OF OAK FOREST
RATE APPROVAL REQUEST

EMPLOYEE: Arthur Roman	HIRE DATE: 10-27-14
EFFECTIVE DATE: 10-27-15	DATE ISSUED: 10-21-15
From: $45,489	Total Pay: $45.489
To: $61,260 Education Incentive $1,440	Total Pay: $62,700
Pay Per Hour: $30.14	Time & ½ Rate: $45.21
Job Classification: Police Officer	
Reason for Request: Step Raise Education Incentive	Department: Police

Department Head: Chief Gregory Anderson

Budget Officer Approval: _____

Treasurer Approval: _____

Mayoral Approval: _____

000002

CITY OF OAK FOREST
JUDY NIE
15540 S CENTRAL AVE
OAK FOREST IL 60452

RE: Policy Number 1029994

Enclosed you will find the Group Voluntary Term Insurance Scheduled Benefits Summary page(s). These are for employee(s) who are new applicants on the group effective date or since the original group effective date or for those employee's who have experienced an individual change since their original application.

Please distribute the Scheduled Benefits Summary to your employee(s) who are new applicants along with a copy of the Group Voluntary Term Insurance Booklet. If an insured is not a new applicant but has experienced a recent change to their individual coverage, please distribute to your employee(s) so they can attach to their booklet.

If you have any questions, you may contact the administrator reflected on your billing statement, or call 1-800-986-EDGE.

Principal Life Insurance Company

RECEIVED
NOV 24 2014

Principal Financial Group

GROUP VOLUNTARY TERM LIFE
SCHEDULED BENEFITS SUMMARY
AS OF 11/17/2014

ARTHUR ROMAN
9306 WALNUT LN
TINLEY PARK IL 60487

Certificate Number: 718
Certificate Effective Date: 12/01/2014
Certificate Anniversary Date: October 1
Policy #: 1029994

CURRENT SUMMARY	AMOUNT
Member Life Benefit	$100,000
POLICYHOLDER:	CITY OF OAK FOREST GVT1029994

Please attach this Scheduled Benefits Summary to your Booklet-Certificate. It replaces any previously issued Scheduled Benefits Summary. If you have any questions, call us at 1-800-843-1371, 7:00 am - 6:00 pm C.T. Monday-Friday.

Burkhardt, Scott

From: Burkhardt, Scott
Sent: Friday, November 07, 2014 11:52 AM
To: O'Connor, Cathy
Cc: Julian, Colleen; Nie, Judy; Alyson Drinkwater (alyson.d@thorntonpowell.com)
Subject: 10-27-14 New Employee Arthur Roman (FT Police Officer)
Attachments: 20141107111139.pdf

Alyson – Health is Mil Max HMO Single plus one (for Roman and his son), no dental, life is $75K plus the $100K additional non-medical total of $175K.

Cathy – 457 (IPPFA) attached @ $40/paycheck.

Tks./S

Scott Burkhardt
City Clerk/Collector
City of Oak Forest
15440 South Central Avenue
Oak Forest, IL 60452
Telephone (708) 444-4810
Fax (708) 535-0014
sburkhardt@oak-forest.org

1139 11-07-14

Form W-4 (2014)

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

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2014 expires February 17, 2015. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,000 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity iincome, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2014. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	A	
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	B	
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	C	
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	D	
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	E	
F	Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F	
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 and $119,000 if married), enter "1" for each eligible child	G	
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ▶	H	

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

Separate here and give Form W-4 to your employer. Keep the top part for your records.

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

Employee's Withholding Allowance Certificate

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

OMB No. 1545-0074

2014

1 Your first name and middle initial	Last name	2 Your social security number
M. Arthur G.	Roman	718

Home address (number and street or rural route): 9306 Walnut Ln.

City or town, state, and ZIP code: Tinley Park, IL, 60487

3 ☒ Single ☐ Married ☐ Married, but withhold at higher Single rate.
Note. If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.

4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐

5	Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)	5 0
6	Additional amount, if any, you want withheld from each paycheck	6 $
7	I claim exemption from withholding for 2014, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ▶	7	

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

Employee's signature (This form is not valid unless you sign it.) ▶ Arthur Roman Date ▶ 10/27/14

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

Illinois Withholding Allowance Worksheet

General Information

Complete this worksheet to figure your total withholding allowances.

Everyone must complete Step 1.

Complete Step 2 if

- you (or your spouse) are age 65 or older or legally blind, or
- you wrote an amount on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4.

If you have more than one job or your spouse works, you should figure the total number of allowances you are entitled to claim. Your withholding usually will be more accurate if you claim all of your allowances on the Form IL-W-4 for the highest-paying job and claim zero on all of your other IL-W-4 forms.

You may reduce the number of allowances or request that your employer withhold an additional amount from your pay, which may help avoid having too little tax withheld.

Step 1: Figure your basic personal allowances (including allowances for dependents)

Check all that apply:

☐ No one else can claim me as a dependent.

☐ I can claim my spouse as a dependent.

1 Write the total number of boxes you checked. 1 _____

2 Write the number of dependents (other than you or your spouse) you will claim on your tax return. 2 _____

3 Add Lines 1 and 2. Write the result. This is the total number of basic personal allowances to which you are **entitled**. 3 _____

4 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of basic personal allowances or have an additional amount withheld. Write the total number of basic personal allowances you elect to claim on Line 4 and on Form IL-W-4, Line 1. 4 _____

Step 2: Figure your additional allowances

Check all that apply:

☐ I am 65 or older. ☐ I am legally blind.

☐ My spouse is 65 or older. ☐ My spouse is legally blind.

5 Write the total number of boxes you checked. 5 _____

6 Write any amount that you reported on Line 4 of the Deductions and Adjustments Worksheet for federal Form W-4. 6 _____

7 Divide Line 6 by 1,000. Round to the nearest whole number. Write the result on Line 7. 7 _____

8 Add Lines 5 and 7. Write the result. This is the total number of additional allowances to which you are **entitled**. 8 _____

9 If you want to have additional Illinois Income Tax withheld from your pay, you may reduce the number of additional allowances or have an additional amount withheld. Write the total number of additional allowances you elect to claim on Line 9 and on Form IL-W-4, Line 2. 9 _____

Note If you have non-wage income and you expect to owe Illinois Income Tax on that income, you may choose to have an additional amount withheld from your pay. On Line 3 of Form IL-W-4, write the additional amount you want your employer to withhold.

✂ – – – – – – – – – Cut here and give the certificate to your employer. Keep the top portion for your records. – – – – – – – – – ✂

Illinois Department of Revenue

IL-W-4 Employee's Illinois Withholding Allowance Certificate

Social Security number 718

Name M. Arthur E. Roman

Street address 9306 Walnut Ln.

City Tinley Park State IL ZIP 60487

Check the box if you are exempt from federal and Illinois Income Tax withholding. ☐

1 Write the total number of basic allowances that you are claiming (Step 1, Line 4, of the worksheet). 1 0

2 Write the total number of additional allowances that you are claiming (Step 2, Line 9, of the worksheet). 2 0

3 Write the additional amount you want withheld (deducted) from each pay. 3 0

I certify that I am entitled to the number of withholding allowances claimed on this certificate.

Your signature [signature] Date 10/27/14

Employer: Keep this certificate with your records. If you have referred the employee's federal certificate to the IRS and the IRS has notified you to disregard it, you may also be required to disregard this certificate. Even if you are not required to refer the employee's federal certificate to the IRS, you still may be required to refer this certificate to the Illinois Department of Revenue for inspection. See Illinois Income Tax Regulations 86 Ill. Adm. Code 100.7110.

IL-W-4 (R-12/07)

This form is authorized as outlined by the Illinois Income Tax Act. Disclosure of this information is REQUIRED. Failure to provide information could result in a penalty. This form has been approved by the Forms Management Center. IL-492-0039

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

►START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 Names Used *(if any)*
Roman	M. Arthur	E	

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code
9306 Walnut Ln		Tinley Park	IL	60487

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
[illegible]			

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.

ALL 7 B

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

- [x] A citizen of the United States
- [ ] A noncitizen national of the United States *(See instructions)*
- [ ] A lawful permanent resident (Alien Registration Number/USCIS Number): _____
- [ ] An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:
Arthur Roman	10/07/2014

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			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

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1: ROMAN M. ARTHUR E.

List A OR List B AND List C			
Identity and Employment Authorization	**Identity**		**Employment Authorization**
Document Title:	Document Title: ILLINOIS DRIVERS LICE		Document Title: SSCARD FR
Issuing Authority:	Issuing Authority: STATE OF ILLINOIS		Issuing Authority: DHHS
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)*: NA
Document Title:	ALL 71B		
Issuing Authority:			
Document Number:			
Expiration Date *(if any)(mm/dd/yyyy)*:			
Document Title:			
Issuing Authority:			
Document Number:			
Expiration Date *(if any)(mm/dd/yyyy)*:			

3-D Barcode 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)*: 10-27-2014 **(*See instructions for exemptions.*)**

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
	11-04-2014	CITY CLERK

Last Name *(Family Name)*	First Name *(Given Name)*	Employer's Business or Organization Name
BURKHARDT	SCOT	CITY OF OAK FOREST

Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State	Zip Code
15440 S. CENTRAL AVENUE	OAK FOREST	IL	60452

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

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

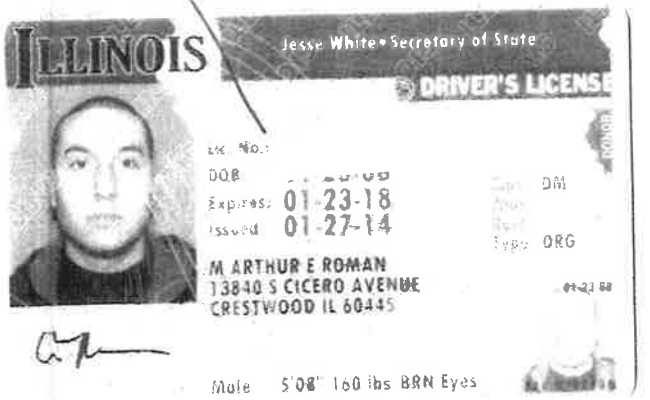
C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

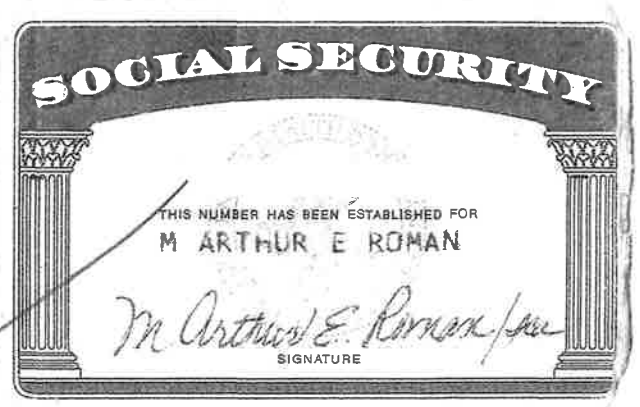
Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

71B


ILLINOIS
Jesse White • Secretary of State
DRIVER'S LICENSE
DOB
Expires: 01-23-18
Issued 01-27-14
Type: ORG
M ARTHUR E ROMAN
13840 S CICERO AVENUE
CRESTWOOD IL 60445
Male 5'08" 160 lbs BRN Eyes


SOCIAL SECURITY
THIS NUMBER HAS BEEN ESTABLISHED FOR
M ARTHUR E ROMAN
M Arthur E. Roman Jr.
SIGNATURE

71B

State of Illinois
Department of Employment Security

New Hire Reporting Form

Employers must report each new hire within 20 days. **Assistance: 1 800 327-HIRE (4473)**

Please print or type

EMPLOYER NAME AND ADDRESS

Federal Employer ID Number - FEIN 36 - 6007749

Company Name City of Oak Forest

Street Address 15440 South Central Avenue

Street Address

City Oak Forest *State* IL *Zip Code* 60452 - 2104

EMPLOYER ADDRESS FOR CHILD SUPPORT WAGE WITHHOLDING ORDERS

Street Address

Street Address

City *State* *Zip Code* -

718

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number - - *Date of Hire (MM-DD-YYYY)* 10 - 27 - 2014

First Name Arthur *MI* E *Last Name* Roman

Street Address 9306 Walnut Ln.

City Tinley Park *State* IL *Zip Code* 60487 -

NEW EMPLOYEE NAME AND ADDRESS

Social Security Number *Date of Hire (MM-DD-YYYY)* - -

First Name *MI* *Last Name*

Street Address

City *State* *Zip Code* -

Return your completed form either by FAX 1-217-557-1947
or by mail to IDES, P.O. Box 19473, Springfield, IL 62794--9473
or report new hires online at http://www.ides.state.il.us/employer/newhire/general.asp

TRANSMISSION VERIFICATION REPORT

TIME : 11/04/2014 11:48
NAME : CITY OF OAK FOREST
FAX : 7086870014
TEL : 7086870014
SER.# : 000K5J926292

DATE,TIME	11/04 11:48
FAX NO./NAME	12175571947
DURATION	00:00:27
PAGE(S)	01
RESULT	OK
MODE	STANDARD ECM

State of Illinois
Department of Employment Security

New Hire Reporting Form

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Federal Employer ID Number - FEIN 36 - 6007749

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Street Address 15440 South Central Avenue

Street Address

City Oak Forest *State* IL *Zip Code* 60452 - 2104

EMPLOYER ADDRESS FOR CHILD SUPPORT WAGE WITHHOLDING ORDERS

Street Address

Street Address

City *State* *Zip Code* -

NEW EMPLOYEE NAME AND ADDRESS

(718)

Social Security Number

Date of Hire (MM-DD-YYYY) 10 - 27 - 2014

First Name Arthur *MI* E *Last Name* Roman

Street Address 9201-

City of Oak Forest

Direct Deposit Authorization

Do you want to have Direct Deposit? Yes [X] No [ ]

If YES, please attach a voided check to this form and forward to payroll.

Employee Name: Arthur E. Roman

Bank Name/Branch: JP Morgan Chase

Bank Transit Number: [redacted] 71B

Account Number: [redacted] 71B

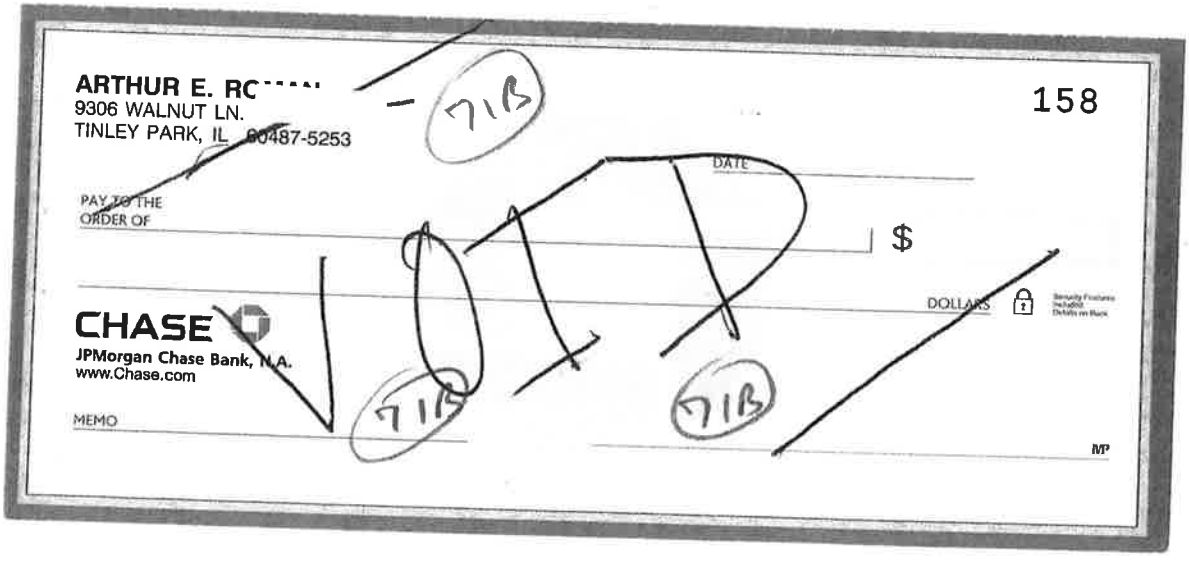
Check Box: Checking [X] Savings [ ]

[ ] **I would like to cancel my direct deposit authorization.**
The undersigned hereby cancels the authorization for direct deposit.

The undersigned hereby requests and authorizes the amount of my paycheck each pay period to be deposited directly into the bank account named above.

Employee Signature

10/27/2014
Date



Illinois Standard Health Employee Application for Small Employers

INSURER USE ONLY
Policy/Group No.
Section No.
Effective Date
New Hire Waiting Period

For assistance in completing this application, please contact your employer or insurance agent. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies.

The information you provide in this application will be sent to the following insurance companies:
(To be completed by employer)
Insurer: BCBS Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____ Insurer: _____

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

TO BE COMPLETED BY EMPLOYER

Employer Name: City of OAK FOREST Phone #: 708-444-4810

Address: 15440 S. CENTRAL AVE., OAK FOREST, IL 60452

Reason for Enrollment (Mark all that apply)

New Enrollment: ☐ New Group ☐ Open Enrollment ☒ New Hire (Date: 10-27-2014) ☐ Late Enrollee

Special Enrollment: ☐ Adoption ☐ Court Order ☐ Dependent Addition ☐ Divorce ☐ Domestic Partner ☐ Loss of Coverage ☐ Marriage ☐ Newborn ☐ Other Date of Event: ____/____/____

Employment Status: ☒ Active ☐ Retiree (Retirement Date: ____/____/____)
☐ Illinois Continuation ☐ COBRA
☐ Employee ☐ Dependent
Qualifying Event: _____
Start Date ____/____/____ Projected End Date ____/____/____

A Employee Information

Name (Last) Roman (First) Arthur (MI) E

Job Title: Police Officer Hire Date: 10/27/2014 Hrs/Week: 40

Marital Status: ☐ Married ☒ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Home Address: 9306 Walnut Ln Apt #:

City: Tinley Park (IL) State: IL Zip: 60487

Home (or Cell) Phone: ( ) Business Phone: ( )

Email Address (optional):

B Coverage Requested

Medical

Employee: ☒ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☒ No Child(ren): ☒ Yes ☐ No

Plan Choice: HMO (mile MAX) Plan Choice: Plan Choice: HMO (mile MAX)

If you are **waiving (declining)** coverage for yourself or any member of your family, you must complete Section C below.

Employer Name CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

Employee Name Roman, Arthur E

Waiver of Coverage

Please complete this section only if **you are waiving (declining) coverage** for yourself or one or more of your family members.

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

- If I am declining coverage for myself, my spouse/domestic partner, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse/domestic partner, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.
- If I have a new spouse/domestic partner or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse/domestic partner or child provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- If I decide to request coverage in the future, for a reason other than the termination of other coverage or the addition of a new spouse/domestic partner or child, I may be considered a late enrollee, if applicable, or I may have to wait until the plan's next open enrollment period. I also understand that as a late enrollee, coverage for preexisting conditions may be excluded for up to a period of 18 months. This period may be offset by the time I, my spouse/domestic partner, or my dependent child(ren) was covered under a qualified health plan.

I certify that I was not pressured, forced, or unfairly induced by my employer, the agent, or the insurer(s) into waiving or declining the group coverage.

I DO NOT want, and hereby waive, coverage for (initial next to all that apply):

Medical for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)
Dental* for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)
Vision* for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)
Basic Life* for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)
Dependent Life* for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)
Voluntary Life* for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)
Short-Term Disability* for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)
Long-Term Disability* for	[	] Myself	[	] My Spouse/Domestic Partner	[	] My Dependent Child(ren)

* If offered.

I am **declining** group coverage for the following reason(s): (check all that apply)

- ☐ Spouse/Domestic Partner's Employer Plan
- ☐ Individual Coverage (Non-Group Plan)
- ☐ COBRA/State Continuation
- ☐ Medicare or other Government Program
- ☐ Other (please explain): _____

✪ **If you are declining ALL coverage for ALL persons, please skip to the Acknowledgement & Signature section on page 10 of this application.**

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

Employee Name Roman, Arthur E

D Individuals Requesting Coverage

List yourself and all eligible family members to be included under coverage.

- Please check with your employer or insurance agent about who may qualify as an eligible family member under the policy.
- Illinois' Young Adult Dependent Coverage law allows parents to cover children up to the age of 26, and up to age 30 for military veteran dependents, regardless of whether the child may be considered a dependent for tax or other purposes. For more information, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) Roman (First) Arthur (MI) E

Social Security Number: Date of Birth: 71B

Weight: 190 lbs. Height: 5 ft. 9 in. Gender: ☒ Male ☐ Female

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Spouse/Domestic Partner Name (Last) (First) (MI)

Social Security Number: Date of Birth: / /

Weight: lbs. Height: ft. 71B in. Gender: ☐ Male ☐ Female 71B

HMO only (if/when applicable): Primary Care Physician: Physician ID:

71B **Dependent Name** (Last) (First) ✓ (MI) M

Social Security Number: Date of Birth:

Weight: 45 lbs. Height: 3 ft. 10 in. Gender: ☒ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☒ No 71B

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Dependent Name (Last) (First) (MI)

Social Security Number: Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Dependent Name (Last) (First) (MI)

Social Security Number: Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: Physician ID:

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

Employer Name _____ Employee Name Roman, Arthur E

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: Physician ID:

E Current/Prior Coverage Information

Please indicate for EACH person listed on this application any health coverage, including Medicare or Medicaid, in effect within **24 months** prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the **past 24 months**, please indicate **NONE.** If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation showing who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. You will be subject to an automatic PEC Waiting Period of up to 12 months until the insurer receives evidence of prior coverage.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) Roman (First) Arthur (MI) E

Current/Most Recent Coverage: ☒ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: 01 / 01 / 2014 To: 06 / 01 / 2014
Policyholder Name: Arthur Roman Insurer Name: _____
Will the individual continue this coverage? ☐ Yes ☒ No

Prior Coverage (if any): ☒ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

Current/Most Recent Coverage: ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____
Will the individual continue this coverage? ☐ Yes ☐ No

Prior Coverage (if any): ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____

Dependent Name (Last) _____ (First) _____ (MI) M

Current/Most Recent Coverage: ☒ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: 01 / 01 / 2014 To: 06 / 01 / 2014
Policyholder Name: Arthur Roman Insurer Name: _____
Will the individual continue this coverage? ☐ Yes ☐ No

Prior Coverage (if any): ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

Employee Name Roman, Arthur E

Dependent Name (Last) ______ (First) ______ (MI) ______

Current/Most Recent Coverage: ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ___/___/___ To: ___/___/___
Policyholder Name: ______ Insurer Name: ______
Will the individual continue this coverage? ☐ Yes ☐ No

Prior Coverage (if any): ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ___/___/___ To: ___/___/___
Policyholder Name: ______ Insurer Name: ______

Dependent Name (Last) ______ (First) ______ (MI) ______

Current/Most Recent Coverage: ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ___/___/___ To: ___/___/___
Policyholder Name: ______ Insurer Name: ______
Will the individual continue this coverage? ☐ Yes ☐ No

Prior Coverage (if any): ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ___/___/___ To: ___/___/___
Policyholder Name: ______ Insurer Name: ______

Dependent Name (Last) ______ (First) ______ (MI) ______

Current/Most Recent Coverage: ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ___/___/___ To: ___/___/___
Policyholder Name: ______ Insurer Name: ______
Will the individual continue this coverage? ☐ Yes ☐ No

Prior Coverage (if any): ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: ___/___/___ To: ___/___/___
Policyholder Name: ______ Insurer Name: ______

Medicare: If you or any family members listed on this application have Medicare coverage, please complete the following information.

Enrolling Individual Name (Last) ______ (First) ______ (MI) ______
Medicare ☐ Part A ☐ Part B ☐ Part D
Effective Date: ___/___/___
Medicare Number (please include alpha prefix):
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

Enrolling Individual Name (Last) ______ (First) ______ (MI) ______
Medicare ☐ Part A ☐ Part B ☐ Part D
Effective Date: ___/___/___
Medicare Number (please include alpha prefix):
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

Employer Name _____ Employee Name Roman Arthur E

F Health Statement

Instructions:

1. The information you provide in this application is confidential. You should discuss with your employer if you prefer to submit the completed health statement directly to the insurance company or insurance broker.
2. The health information you provide below will be used by the insurance company to determine the price to charge your group for the coverage applied for and whether a Pre-Existing Condition Waiting Period(s) will apply to your coverage. Coverage for pre-existing conditions cannot be limited or excluded for dependents under the age of 19.
3. Each medical question below applies to all persons requesting coverage.
4. Answer the questions below with either Yes or No. If you answer Yes to any question, you must provide additional information in Section G below.
5. Do not leave any question unmarked.
6. Neither your employer nor your insurance agent can waive these requirements or may authorize you to provide anything less than a complete and accurate response to each of the questions.
7. After you submit this application, the insurance company may call you to obtain additional confidential information needed to evaluate and aid the processing of your application.

1 For the following conditions, **within the past 5 years**, have you or any dependents for whom you are requesting coverage:

- Been tested for or diagnosed with;
- Had medical treatment recommended;
- Received medical treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition related to any of the categories listed below?

A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other disease or disorder of the heart, arteries, blood, or blood vessels?	[Yes	No
B. Cancer or cancerous tumor?	[Yes	[No
C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system?	[Yes	[No
D. Diabetes? If yes, check all that apply: ☐Non-Insulin Dependent ☐Insulin Dependent ☐Insulin Pump	[Yes	[No
E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines?	[Yes	[No
F. Growth disorder or a disorder of the pancreas?	[Yes	[No
G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder?	[Yes	No
H. Reproductive organ disorders or infertility?	[Yes	No
I. Arthritis, or any other disorder of the joints, muscles, back, or bones?	[Yes	No
J. Mental or emotional disorder?	[Yes	No
K. Seizures/epilepsy, paralysis, or any other disorder of the brain or nervous system?	[Yes	No

7 1B

L. HIV positive, AIDS, diseases associated with AIDS, lupus, or other disorder of the immune system?	Yes	No
M. Alcohol, drug, or substance use or dependency?	Yes	No
N. Organ or bone marrow transplant?	Yes	No
2 Are you, your spouse/domestic partner, or any dependent for whom you are requesting coverage currently pregnant?	Yes	No
Due Date: ____/____/_____ (MM/DD/YYYY)		
If yes, are multiples (twins, triplets, *etc.*) expected?	Yes	No
Are there any known complications, or is a cesarean section planned?	Yes	No
3 Within the past 12 months, have you or your spouse/domestic partner used any tobacco products? Employee:	Yes	No
Spouse/Domestic Partner:	Yes	No
4 Within the past 12 months, has any applicant been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application?**	Yes	No
5 Within the past 5 years, has any person applying for coverage been tested for or diagnosed with, had medical treatment recommended, received medical treatment, including prescription medications, or been hospitalized for **any illness, injury or health condition not indicated above?**	Yes	No

7 | 8

G Additional Information

If you answered "Yes" to any of the questions above, you must complete this section.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Question Number: _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Question Number: _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

Employer Name: CITY OF OAK FOREST 15440 S CENTRAL AVE OAK FOREST IL 60452 Employee Name: Roman, Arthur E

Question Number: ________ **Name of Individual:** ________________

Condition/Diagnosis: ________________ Date Diagnosed (MM/YYYY): ________

Treatment Received: ________________

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ________________

Surgery, additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________

________________ Currently taking medication? ☐ Yes ☐ No

Question Number: ________ **Name of Individual:** ________________

Condition/Diagnosis: ________________ Date Diagnosed (MM/YYYY): ________

Treatment Received: ________________

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ________________

Surgery, additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________

________________ Currently taking medication? ☐ Yes ☐ No

Question Number: ________ **Name of Individual:** ________________

Condition/Diagnosis: ________________ Date Diagnosed (MM/YYYY): ________

Treatment Received: ________________

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ________________

Surgery, additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________

________________ Currently taking medication? ☐ Yes ☐ No

Question Number: ________ **Name of Individual:** ________________

Condition/Diagnosis: ________________ Date Diagnosed (MM/YYYY): ________

Treatment Received: ________________

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ________________

Surgery, additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________

________________ Currently taking medication? ☐ Yes ☐ No

Question Number: ________ **Name of Individual:** ________________

Condition/Diagnosis: ________________ Date Diagnosed (MM/YYYY): ________

Treatment Received: ________________

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ________________

Surgery, additional tests or treatment recommended? ________________

Medication Prescribed (if any): ________________

________________ Currently taking medication? ☐ Yes ☐ No

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

Employer Name _____ Employee Name Roman, Arthur E

H Additional Coverage Options

You should complete this section only if your employer offers any of the additional coverage options below.

Employee

☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): _____

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $_____

☐ Short-Term Disability ☐ Long-Term Disability

Employee Class (employer will provide you with this information if needed): _____

Salary (if requesting life or disability coverage): $_____

☐ Hourly ☐ Weekly ☐ Monthly ☐ Semi-monthly ☐ Annually

Spouse/Domestic Partner

☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): _____

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $_____

☐ Short-Term Disability ☐ Long-Term Disability

Child(ren)

☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): _____

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $_____

☐ Short-Term Disability ☐ Long-Term Disability

Beneficiary Information (if requesting life insurance)

Primary Beneficiary Name (Last, First, MI) _____

Relationship Son Benefit % 50

Secondary Beneficiary Name (Last, First, MI) Roman, Mario

Relationship Father Benefit % 50

713

CITY OF OAK FOREST
15440 S CENTRAL AVE
OAK FOREST IL 60452

ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

Employer Name _____ Employee Name Roman, Arthur E

I Acknowledgement & Signature

I understand, agree, and represent that:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section B and Section H of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature A. Roman Date 11/1/2014

✪ For assistance in completing this application, please contact your employer or insurance agent.
For information about your health care rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

Principal Financial Group

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - IL

Company name	Benefit class	Account number/unit number
CITY OF OAK FOREST		

Employee Information

Name	Social security number	
Roman, Arthur E		71B
Mailing address (street)	**Birth date**	☒ male ☐ female
9306 Walnut Ln.		
(city) / **(state)** / **(ZIP code)**	**Do you have an eligible spouse or child?**	
Tinley Park / IL / 60487	☒ Yes ☒ No	71B
Date employed full-time	**Hours worked per week**	**Job occupation/class** / **Location**
10/27/2014	40	
Salary amount	**Salary mode**	
P44,379	☒ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly	
What is your payroll mode?	**Employer ZIP**	**Employer county**
☐ monthly ☐ semi-monthly ☐ weekly ☒ bi-weekly	60452	COOK

Group Term Life

Employee:

☒ Elect

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

71B

Name	Percentage	Relationship
[redacted]	50%	Son
Address	**Social security number**	
10347 S. Sawyer Chicago, IL		71B
Name	**Percentage**	**Relationship**
Roman, Mario	50%	Father
Address	**Social security number**	
9306 Walnut Ln Tinley Park, IL		71B
Name	**Percentage**	**Relationship**
Address	**Social security number**	

Contingent Beneficiaries:

Name	Percentage	Relationship
Address	**Social security number**	
Name	**Percentage**	**Relationship**
Address	**Social security number**	

Voluntary Term Life

Employee: ☒ Elect ☐ Decline	$ 75,000 Group or + $100,000 Voluntary = $175,000 total	
Spouse: ☐ Elect ☐ Decline	$	Birth date
Children: ☐ Elect ☐ Decline	$	

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Rhonda, Same as above	50%	SON
Address		Social security number
Name	Percentage	Relationship
Same as above	50%	FATHER
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's group coverage ☐ individual insurance
☐ other _____ ☐ other coverage offered by my employer

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse's name	Birth date	☐ male ☐ female	Social security number	
Name(s) of child(ren)	Birth date	☐ male ☐ female	Social security number	☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child **

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? ☐ Yes ☐ No

** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Is your spouse employed by this company? ☐ Yes ☐ No

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.

- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

A copy of this form will be as valid as the original.

I **declare** that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X _____ **Date Signed** 11/1/2014

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

Principal Financial Group

120

Principal Life Insurance Company | Health Statement – IL

Account number

Instructions for completing this form

1. The Employee Information section should always be completed with the information about the employee (do not include dependent or spouse information here).
2. The employee must ALWAYS sign the last page of this form.
3. When VTL is being requested for a spouse in addition to the employee, please follow the steps below:
   a. If a health statement is needed for each person, a separate page 2 must be completed for the employee and the spouse.
   b. The employee height/weight should be completed on page 2 for the employee and the spouse height/weight should be completed on page 2 for the spouse.
   c. A spouse signature must be included on page 3 of the form.

Employee Information: After completed make a copy of Page 1, Page 2 and Page 3 for your records.

Your name (last, first, middle initial)	Home phone number	Social security number
Roman, Arthur, E	(71B)	(71B)
Home address (street)		
9306 Walnut Ln.		
City	**State**	**ZIP code**
Tinley Park	IL	60487
Date of birth	**Company name**	
01/23/1988	City of Oak Forest	

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life Insurance Company. We will do this by having you complete an application or health statement. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Health Information for All Coverages Being Applied for

To prevent delays give full details to "yes" answers for everyone electing coverage. If more space is needed, attach a separate page giving full details. Sign and date all pages. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height 5 ft. 9 in. weight 180 lbs. Spouse's height ____ ft. _____ in. weight _____ lbs.

1. ☐ yes ☒ no Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests or examinations or taking any medicine or is anyone pregnant (due date _____ any complications _____ C-Section date _____ Multiple births? ☐ yes ☐ no)

2. ☐ yes ☒ no In the past five years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

☐ cancer ☐ alcohol/drug use ☐ arthritis/bone/joint/muscle ☐ skin/eye/ear/nose/throat
☐ tumor ☐ high cholesterol ☐ allergy/asthma/respiratory ☐ kidney/bladder/urinary
☐ infertility ☐ heart/circulatory ☐ digestive/intestinal/eating ☐ stroke/neurological/nervous system
☐ liver/hepatitis ☐ mental/nervous ☐ high blood pressure – last reading and date _____ / _____
☐ diabetes – last HbA1c reading and date _____ / _____ ☐ organ or other transplants
☐ Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder
☐ other – including other meds _____

Name | Date diagnosed/treated | Length of illness or condition

Diagnosis of illness or condition | Type of treatment

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name | Date diagnosed/treated | Length of illness or condition

Diagnosis of illness or condition | Type of treatment

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Name | Date diagnosed/treated | Length of illness or condition

Diagnosis of illness or condition | Type of treatment

Any current symptoms or problems

Names of all medications

Names and addresses of doctors, hospitals or other providers

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life is not liable for anyone's claim which happens or begins before the effective date of coverage or approval of any life and disability coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause life and disability coverages, if issued, to be cancelled as never effective.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I understand all policy provisions for medical coverage will apply. If approved for life and disability coverages, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- For life and disability coverages, I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents and employees performing business transactions, any such data.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for life and disability coverage. This information will not be used for any purposes prohibited by law.

Employee's signature	Date signed 11/1/2014
Spouse's signature*	Date signed

*Spouse signature only required if Voluntary Term Life coverage is elected.

TRANSAMERICA Retirement Solutions 4333 Edgewood Road NE Cedar Rapids, IA 52499

Section A: Employer Information **Enrollment Application**

Company/Employer Name: **The Wise Choice for Public Employees**

☐ New Enrollment
☐ Contribution Change

Contract/Account No.: **PE61743** Affiliate No.: **00001** Division No.: **OKFT**

Section B: Participant Information

Social Security No.: [redacted] Date of Birth (MM-DD-YYYY): [redacted]

First Name/Middle Initial: Arthur E Last Name: Roman

Mailing Address: 9306 Walnut Ln State: IL Zip code: 60487

City: Tinley Park E-mail: [redacted]

Phone No./Ext.: [redacted] Date of Hire (MM-DD-YYYY): 10-27-2014

Marital Status: ☐ Married ☒ Single/Divorced Gender: ☒ Male ☐ Female

Section C: Contributions (By law, any election will not be effective until the following month, except if completed on the first day of employment or earlier.)

☐ I elect to reduce my eligible compensation by _____% (from 1% up to 100% of your pay), each pay period as a pre-tax salary deferral contribution.

☐ I elect to reduce my eligible compensation by _____% (from 1% up to 100% of your pay), each pay period as a Roth salary deferral contribution.

Note: You may apply the age 50 catch-up or the last three taxable years catch-up for any given calendar year.

☐ (For employees who have attained age 50 or will attain age 50 this calendar year) I elect to reduce my eligible compensation, in equal amounts each pay period, as a pre-tax salary deferral catch-up contribution, as indicated below:

☐ Maximum amount each year (contact Transamerica for further information)

☐ As a pre-tax salary deferral contribution.

☐ As a Roth contribution.

☐ $ _____ each year as a pre-tax salary deferral contribution.

☐ $ _____ each year as a Roth contribution.

☐ I am in the last three taxable years ending before the year of my normal retirement age (as defined in the plan) and have underutilized past contributions while eligible. I elect to make additional contributions in accordance with the Special 457(b) Catch-up provision. The catch-up contribution will not exceed the lesser of my underutilized limit or twice the dollar amount of the 457(b) limit allowed for the year that I elect to contribute the catch-up contribution. I elect to make a catch-up contribution: * $40 / check * 26 Bi-weekly Payroll

☒ as a pretax salary deferral contribution, for the taxable year _____ of $1040 or _____%. (whole percentages)

☐ as a Roth contribution, for the taxable year _____ of $_____ or _____%. (whole percentages)

☐ The above election(s) is effective with the payroll period beginning _____ (may not be retroactive).

☐ I elect not to make contributions to this plan.

☐ Contact me to help me consolidate another retirement plan (401K, 403B, IRA, etc) into my new Transamerica account.

Section D: Investment Allocation

1) **One-Step Diversification** - Automatic allocation and reblancing service using all the core funds in your plan.

PortfolioXpress®

☒ Please enroll me in this service. By checking this box **I agree to allocate 100% of my contributions** based on my target retirement year and risk preference:

My target retirement year: 20 44

☐ **I agree** to each of the asset allocation mixes and automated rebalancing transactions that will occur within my account as I approach retirement. I understand that I may turn the service off at any time, or change my designated retirement year and/or risk preference, by signing in to my account at my.trsretire.com or calling Transamerica at 800-755-5801. All future rebalancing transactions are shown on the attached PortfolioXpress Profile, which includes an investment glidepath.

☐ **Maintain my Schwab PCRA** . By checking the box at left I request that any existing balances in my PCRA remain invested. I understand that PCRA balances are not available for investment through PortfolioXpress; that no future contributions will be allocated to my PCRA account; and that **I may not make additional transfers into PCRA while I am using the PortfolioXpress service.**

IMPORTANT: If you wish to liquidate your PCRA account and make the balances available for investment through PortfolioXpress, please call 800-755-5801.

STOP HERE! Do not complete the section below if you have enrolled in PortfolioXpress, which requires a 100% allocation of new contributions to your account. Please go directly to Section E.

2) Create or Choose Your Own Portfolio- Please allocate contributions to the following investment options in the percentages noted below (total must equal 100%):

Choose a Portfolio

C20B	Short Horizon Asset Allocation	%
C35B	Short/Intermediate Horizon Asset Allocation	%
C21B	Intermediate Horizon Asset Allocation	%
C22B	Intermediate/Long Horizon Asset Allocation	%
C36B	Long Horizon Asset Allocation	%

Create a Portfolio

CT4B	Money Market Fund	%
GDAF	TFLIC Stable Fund	%
C15B	High Quality Bond Fund	%
CT5B	Core Bond Fund	%
C0DC	Inflation-Protected Securities Fund	%
C26B	High-Yield Bond Fund	%
CT6B	Large Value	%
C0AC	Large Core	%
C0FC	Stock Index Fund	%
CT1A	Large Growth	%
C40B	Mid Value	%
C39B	Mid Growth	%
C41B	Small Value	%
C0BC	Small Core	%
C42B	Small Growth	%
CRTB	Real Estate Fund	%
C12B	International Equity Fund	%

Section E: Signatures

If I elected the PortfolioXpress service in Section C (Investment Allocation), I hereby acknowledge that I have received and reviewed the attached PortfolioXpress Disclosure Statement and the PortfolioXpress Profile (which includes the Investment Glidepath for PortfolioXpress). I further understand that I may change the amount of my salary reduction, or terminate this agreement, by giving notice in accordance with the terms of my employer's plan.

Balances in a Schwab Personal Choice Retirement Account are not available for investment in the PortfolioXpress service. Should you choose to maintain these assets in PCRA, you will be restricted from making any additional transfers into PCRA. The assets in your PCRA account will remain, and will not be included in the investment strategy provided through this service. If you choose to liquidate your PCRA account, please contact a Transamerica representative.

I understand that any catch-up contributions elected above are not determined to be catch-up contributions until my regular pre-tax salary deferral contributions exceed an applicable limit under the plan, and that the amount of my salary reduction above may not exceed the limits of contributions set forth in my employer's plan.

Transamerica Investors Securities Corporation (TISC), 440 Mamaroneck Avenue, Harrison, NY 10528, distributes securities products. Any registered fund offered under the plan is distributed by that particular fund's associated fund family and its affiliated broker-dealer or other broker-dealers with effective selling agreements such as TISC.

I acknowledge that investment option information, including prospectuses, disclosure documents, and/or fund profile sheets, as applicable have been made available to me and I understand the risks of investing.

The Transamerica funds are distributed by Transamerica Capital, Inc. (TCI) and are advised by Transamerica Asset Management (TAM). Transamerica, TISC, TAM, and TCI are affiliated companies.I understand that the fixed interest option(s) are available under group annuity contract(s) issued by Transamerica Financial Life Insurance Company ("TFLIC") and that the mutual fund options are subject to a Custodial Agreement with State Street Bank and Trust Company ("SSBT"). I understand that the group annuity contracts are legally separate arrangements from the Custodial Agreement. SSBT has no control over or responsibility for the group annuity contracts. I understand that an annual administrative fee, a withdrawal charge, and transfer restrictions may apply.The Transamerica investment options are available under a group variable annuity contract issued by Transamerica Financial Life insurance Company ("TFLIC"), which is offered through Transamerica Investors Securities Corporation, 440 Mamaroneck Avenue, Harrison, NY 10528. I understand that an annual administrative fee, a withdrawal charge, and transfer restrictions may apply.The Stable Pooled Fund is offered through Diversified Investment Advisors Collective Trust and invests directly in the Wells Fargo Stable Return Fund which is a collective trust fund of Wells Fargo.

I agree to the terms of the plan. I am aware that amounts deferred under this type of plan are included in my employer's general assets. I understand that I may change the amount of my salary reduction, or terminate this agreement, by giving notice according to the terms of the plan. I understand that upon termination of my employment, my account will be distributed according to my election and according to the terms of the plan.

X _____ 11/1/2014

Participant Signature — Date

_____ _____

Plan Administrator — Date

TRANSAMERICA®
Retirement Solutions

Beneficiary Designations

Instructions

To designate a beneficiary or to change your existing beneficiary designation on your plan, complete all applicable sections of this form, obtain any required signatures, and return it to your Plan Representative.

☐ Initial Designation ☐ Change of Designation

Section A. Employer Information

Company/Employer Name: City of Oak Forest

Contract/Account No. | Affiliate No. | Division No.

Section B. Personal Information

Social Security No. | Date of Birth (mm/dd/yyyy)

First Name/Middle Initial: Arthur / E | Last Name: Roman

Mailing Address: 9304 Walnut Ln.

City: Tinley Park | State: IL | Zip Code: 60487

Phone No.: 708-268-9791 | Ext.

E-mail Address

Section C. Primary Beneficiary Designation - Will receive benefits in the event of your death

This designation will apply to the account number above. You must designate a specific percentage for each beneficiary. Shares must be whole percentages and total 100%. If you do not indicate shares, benefits will be split equally among surviving beneficiaries. If the named beneficiary is a trust, please specify the name and date of the trust, and the name of the trustee.

Note: Share of benefits must total 100% for primary beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Share of Benefits: 50 % (whole percentages only) | Relationship: Son

Last Name | Date of Birth (mm/dd/yyyy)

First Name/Middle Initial | Social Security No.

Mailing Address: 10347 S. Sawyer

City: Chicago | State: IL | Zip Code: 60655

Primary Beneficiary Designation (continued)

Share of Benefits: 50 % (whole percentages only) Relationship Father

Last Name Roman Date of Birth (mm/dd/yyyy) 07/26/1957 (71B)

First Name/Middle Initial Mario Social Security No.

Mailing Address 9306 Walnut Ln.

City Tinley Park State FL Zip Code 60487

Section D. Contingent Beneficiary(ies) - Will receive benefits if no primary beneficiary is living at the time of your death

Note: Share of benefits must total 100% for contingent beneficiaries. If additional space is needed to designate multiple beneficiaries, complete the Supplemental Beneficiary Designation page.

Share of Benefits: % (whole percentages only) Relationship

Last Name Date of Birth (mm/dd/yyyy)

First Name/Middle Initial Social Security No.

Mailing Address

City State Zip Code

Share of Benefits: % (whole percentages only) Relationship

Last Name Date of Birth (mm/dd/yyyy)

First Name/Middle Initial Social Security No.

Mailing Address

City State Zip Code

Section E. Participant Signature

I certify that the information provided on this form is correct and complete.

X [signature] X 11/1/2014

Participant Signature Date

X Arthur Roman X _____

Print Name Social Security Number

Section F. Plan Representative Signature

I certify that the information provided on this form is correct and complete.

X _____ X _____

Plan Representative Signature Date

Supplemental Beneficiary Designations

Social Security No. [ ]

First Name/Middle Initial: Arthur / E Last Name: Roman

Note: Share of benefits must total 100% for primary beneficiaries *(will receive benefits in the event of your death)* ***AND 100% for contingent beneficiaries*** *(will receive benefits if no primary beneficiary is living at the time of your death).*

☑ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Share of Benefits: 50 % (whole percentages only) Relationship: Son

Last Name: Roman Date of Birth (mm/dd/yyyy): [ ]

First Name/Middle Initial: Bennett Social Security No. [ ]

Mailing Address: 10377 S. Sawyer

City: Chicago State: IL Zip Code: 60655

☒ **Primary Beneficiary** ☐ **Contingent Beneficiary**

Share of Benefits: 50 % (whole percentages only) Relationship: Father

Last Name: Roman Date of Birth (mm/dd/yyyy): 07/26/1957

First Name/Middle Initial: Mario Social Security No. [ ]

Mailing Address: 9306 Walnut Ln.

City: Tinley Park State: IL Zip Code: 60487

CITY OF OAK FOREST
Growing Families,
Building a Community.

15440 South Central Avenue Oak Forest, Illinois 60452-2195
708.687.4050 • Fax 708.687.8817 • www.oak-forest.org

NEW EMPLOYEE
ARTHUR ROMAN
OAK FOREST.
IPPFA 4-7

FACSIMILE COVER SHEET

To: JOE BABBITT

Fax Number: 773-427-6875

From: **City Clerk Scott Burkhardt**
Direct: (708) 444-4810
Clerk's Office Fax Number: (708) 535-0014
E-mail: sburkhardt@oak-forest.org

Date: 11-07-14

Total Number of Pages (Including Cover Sheet): 8

Comments:

JOE - AS ATTACHED.

S

TRANSMISSION VERIFICATION REPORT

TIME : 11/07/2014 16:26
NAME : CITY OF OAK FOREST
FAX : 7086870014
TEL : 7086870014
SER.# : 000K5J926292

DATE,TIME	11/07 16:22
FAX NO./NAME	17734276875
DURATION	00:03:54
PAGE(S)	08
RESULT	OK
MODE	STANDARD ECM

15440 South Central Avenue Oak Forest, Illinois 60452-2195
708.687.4050 • Fax 708.687.8817 • www.oak-forest.org

NEW EMPLOYEE
Barbara Romano
OAK FOREST
IPPFA 4-17

FACSIMILE COVER SHEET

To: Joe Babbitt

Fax Number: 773-427-6875

From: **City Clerk Scott Burkhardt**
Direct: (708) 444-4810
Clerk's Office Fax Number: (708) 535-0014
E-mail: sburkhardt@oak-forest.org

Date: 11-07-14

Total Number of Pages (Including Cover Sheet): 8

Comments:

Employee Benefits Corporation

The EBC HRA℠
Section 105 Administration

Add/Change/ Delete Form
1

EBC Only

EBC Group ID Number

EBC Specialist

Processed Date

Please Complete When Faxing:

Return Fax Number | Date (mm/dd/yyyy) | No. of Pages

Company Information ALWAYS complete this section

City of Oak Forest
Company Name

Payroll Department Signature (optional) | 10-04-14 Date (mm/dd/yyyy)

Employee ALWAYS complete this section

Arthur | E | Roman | 718
First Name | Middle Initial | Last Name | Social Security Number

Add An Employee Complete this section ONLY if adding an employee

10/27/2014 | 718
Date of Hire (mm/dd/yyyy) | Date of Birth (mm/dd/yyyy)

9306 Walnut Ln | Tinley Park | IL | 60487
Mailing Address | City | State | Zip

Single + 1 | Coverage Amount (List prorated amount, if applicable) | Effective Date
Coverage Type (Single, family, limited family, etc.)

Employee Name Change Complete this section ONLY when requesting a name change

From | To | Effective Date

Employee Address Change Complete this section ONLY when requesting an address change

Street Address | City | State | Zip

Employee Coverage Change Complete this section ONLY when requesting a coverage change

From (Coverage type and amount) | To (Coverage type and amount; any previous reimbursements will be subtracted from this amount) | Effective Date

Give a brief reason for coverage change

Employee "Post-Employment Benefit"

Complete this section ONLY if the EBC HRA plan design provides a "Post-Employment Benefit" option

"Post-Employment Benefit" allows participants to use all or a portion of the balance remaining in their EBC HRA for eligible expenses for a specified period of time after they are no longer employed by the employer

Does the Employee qualify to have their EBC HRA account balance converted into a "Post-Employment Benefit" account? ○ Yes ○ No

$ | Years:
Enter the dollar amount of the remaining balance to be converted | Enter the duration of the account (years)

Employee Termination Complete this section ONLY when requesting an employee termination

Termination Date (mm/dd/yyyy)

Give a brief reason for termination from plan

Web Address:
www.ebcflex.com

U.S. Mail:
Employee Benefits Corporation
PO Box 44347
Madison WI 53744-4347

Phone:
Monday - Friday, 8:00 - 5:00 CST
608 831 8445
800 346 2126

Fax:
608 831 4790

426-3 05/06

CITY OF OAK FOREST
RATE APPROVAL REQUEST

EMPLOYEE: Arthur Roman	HIRE DATE: 010-27-14
EFFECTIVE DATE: 10-27-14	DATE ISSUED: 10-27-14
From:	Total Pay:
To: $44,379	Total Pay: $44,379
Pay Per Hour: $21.34	Time & ½ Rate: $32.01
Job Classification: Police Officer	
Reason for Request: Probation/Start	Department: Police

Department Head: Chief Gregory Anderson

Budget Officer Approval: _____

Treasurer Approval: _____

Mayoral Approval: _____

APPENDIX B

EMPLOYEE POLICY MANUAL ACKNOWLEDGMENT

I hereby acknowledge receipt of the City of Oak Forest Personnel Policy Manual. I agree and represent that I have read this Manual in its entirety and agree that if there is any policy or provision that I do not understand, I will seek clarification from my supervisor, department head or City Administrator.

I understand that this manual is only a reference guide and is not intended to create or does create an employment contract, either express or implied, on the part of the City. I understand that the policies, benefits and rules contained in this Manual can be changed or discontinued at any time, with or without advance notice.

I understand and will comply with all policies within this Manual and acknowledge that violating any policy within this Manual or any other City policy, rule or guideline will subject me to disciplinary action.

Employee Name: Arthur E. Roman

Employee Signature: A. Roman

Date: 11/4/14

APPENDIX A

INTERNET, EMAIL & COMPUTER USE ACKNOWLEDGMENT

I hereby acknowledge that I have received a copy of the City's Internet, Electronic Mail and Computer Usage policy. I understand that my use of the City email and Internet system constitutes my consent to all the terms and condition of the policy. I understand that the email system and all information transmitted by, received or stored in the system are the property of the City and is only to be used for business purposes.

I further acknowledge that I have no expectation of privacy in the connection with the use of the Internet and email system or with the transmission, receipt or storage of information in that system. I consent to the City's monitoring of my use of the email and Internet, including the printing and reading all emails entering, leaving or stored in the system.

Employee Name: Arthur E. Roman

Employee Signature: [signature]

Date: 11/4/14

CITY OF OAK FOREST
EMPLOYEE SAFETY CODE

Notice of Receipt:

I hereby acknowledge receipt of the City of Oak Forest's Employee Safety (Safety Code) and signify that I will read this Safety Code and abide by its contents.

I will retain the Safety Code while employed by the City and will consult with my superior on any rule within the Safety Code on which I am in doubt.

Subsequent safety policy changes to the Safety Code will be made available to me by my Supervisor. I will adhere to each of the rules in the Safety Code.

Signature of Employee

11/7/14
Date Returned

Oak Forest Police Department
15440 S. Central Ave.
Oak Forest IL, 60452

Officer Arthur Roman #184
Oak Forest Police Department

March 2, 2016

Administrative Leave with Pay

I am in receipt of your email dated February 29, 2016 in which you advise that you were arrested by the Huntington Beach Police Department on a charge of Assault with a Deadly Weapon. Since such an arrest and charge may impact your ability to act as a sworn police officer, you are hereby placed on Administrative Leave with Pay pending the outcome of the internal investigation by the Oak Forest Police Department. Such administrative leave is covered under General Order 26.1 as listed below:

Section IX - Administrative Leave

A. In certain circumstances, it may be appropriate to place a member on administrative leave. The placement of a member on administrative leave shall not be considered discipline, and members in this status shall continue to be paid, accrue seniority, and receive normal benefits.

B. Administrative leave may be used in instances where a member must be removed from duty until a proper investigation or other administrative proceeding can be held. Usually the situation involves a case of suspected misconduct of a serious nature, or an issue relating to a member's physical or mental fitness for duty. In such cases, leaving the member to perform normal duties would create potential liability for the member, the Department, and the City.

In addition, you are required to cooperate with the internal affairs investigation into this matter and a separate Employee Complaint Notification – Disclosure of Information form will be included with this letter. This level of cooperation includes being available to provide information and be interviewed as ordered.

During your administrative leave, you must be available to the department during your normal working hours as if you were not on leave. You are also required to follow all orders, policies and procedures of the department. This includes taking of personal time off such as vacations, compensatory time, etc. unless with the written permission of myself or Deputy Chief Kristin.

You are also hereby ordered not to act as a police officer in any official capacity except to provide testimony as required by the courts. A copy of this letter will be forward to the Cook County State's Attorney office. You are also hereby ordered to contact Deputy Chief Kristin and surrender you department issued weapon and police badges immediately.

You should be aware that the outcome of an internal affairs investigation is not dependent on the outcome of a criminal investigation/court case. As such, the department will conduct an investigation as it pertains to violations of policy.

If you have any questions, please do not hesitate to contact me.

Gregory J. Anderson
Chief of Police