



# New Benefited Employee Pre-Employment Paperwork

ePAF#

*All new employees appointed to the University must complete the attached pre-employment paperwork within two weeks of receipt in order to be placed on the University's payroll system by their start date. Return all properly completed forms to the Office of Human Resources, Third Floor Quinn Administration Building.*

## Section I. Completed by appointee:

### 1. How to apply for a Social Security Card

All employee must have a Social Security Number. Please follow step to apply for Social Security Number.

### 2. Personal Data Questionnaire (PDQ)

You must complete, sign and date the bottom of the form.

### 3. University of Massachusetts Boston, Self-Identification Form

It is the policy of the University of Massachusetts to collect, maintain, and report certain ethnicity, race, disability, and Vietnam Era Veteran status information as required by federal and state entities. **Completion of any part of this form is strictly voluntary, but will enable the University to accurately report the diversity of its faculty and staff and to monitor the effectiveness of its affirmative action programs.** Any data collected as part of this process will not be used to make employment-related decisions. The University's policy on the collection, maintenance, and reporting of such information is available at: [www.umb.edu/odei](http://www.umb.edu/odei)

### 4. Voluntary Self-Identification of Disability

**Completion of any part of this form is strictly voluntary, but will enable the University to accurately report the diversity of its faculty and staff and to monitor the effectiveness of its affirmative action programs.** Any data collected as part of this process will not be used to make employment-related decisions. The University's policy on the collection, maintenance, and reporting of such information is available at: [www.umb.edu/odei](http://www.umb.edu/odei)

### 5. State Board of Retirement New Member Enrollment Form

All active state employees are required to contribute a percentage of their salary towards their retirement. This contribution is deposited into an annuity account on behalf of the member. A statement of the annuity account balance is mailed to all active members yearly. Refer to [www.mass.gov/treasury/retirement/state-board-of-retire](http://www.mass.gov/treasury/retirement/state-board-of-retire) for information.

6. Statement Concerning Your Employment in a Job Not Covered by Social Security (Form SSA – 1945) You must sign and date this form, which explains how a pension from this new position could affect future Social Security benefits to which you may become entitled (as per the Social Security Protection Act of 2004)

### 7. Mandatory Direct Deposit

Your payroll check will be deposited directly into your account: checking, savings, credit union, etc. The University offers the ability to have your check deposited into a combination of up to four accounts.

### 8. Conflict of Interest Law Requirements

Annual conflict of interest law education and training is mandated by the University of Massachusetts Boston and the Commonwealth of Massachusetts.

### 9. Glacier - Nonresident Alien Tax Compliance System

Non-Resident Aliens must contact [Quan.Tran@umb.edu](mailto:Quan.Tran@umb.edu) in Human Resources for additional information. For non-resident aliens, there may be tax implications if you do not complete and submit the form. This may result in additional withholdings and/or penalties from the Internal Revenue Service. The university will not adjust your tax forms if you do not complete them nor is the university financially responsible to refund any tax penalties.

The University of Massachusetts Boston is not responsible for determining your withholding allowance. If you have questions on exemptions, withholdings and/or any other tax related questions please contact the Internal Revenue Service directly at [www.irs.gov](http://www.irs.gov).

**10. Massachusetts Disclosure Form**

If applicable, complete the form by including the name(s) of family members who are employed by the state.  
*Note: If you completed the form via Interview Exchange, UMB's Applicant Tracking System you do not need to resubmit*

**11. Computer Awareness and Data Security Compliance Statement**

You must sign and date the bottom of the form.

**Section II. Completed by appointee and university representative:**

**Employment Eligibility Verification Form (Form I9) \*\*\*Please read instructions thoroughly\*\*\***

Newly hired employees must complete Section 1 of this form no later than their first day of employment. Human Resources must complete Section 2 of Form I9 within three (3) business days of the first day of employment after reviewing the original documents presented. An appointee must provide documents within three days of their date of hire that will verify identity as well as U.S. employment eligibility.

**Section III. Received by appointee:**

By signing below, appointee acknowledges receipt and understanding of the University policies listed below. The policies can be downloaded as a packet from the Forms page on the HR website:

<https://hr.umb.edu/policies>

- Data Security, Electronic Mail, and Computer Policy Development (Doc. T097-010)
- Drug-Free Workplace Policy
- Federal Affordable Care Act (ACA) notification/information
- Guide to the Conflict of Interest Law
- Guide to Political Activity (Public Employees and Fundraising)
- Massachusetts Pregnant Workers Fairness Act
- Non-Discrimination and Harassment Policy (Doc. T16-040)
- Sexual Harassment Policy (Doc. T92-037)
- University of Massachusetts Boston Background Check Policy
- University of Massachusetts Policy on Fraudulent Financial Activities (Doc. T00-051)
- University of Massachusetts Principles of Employee Conduct (Doc T96-136)

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*I have received, completed, and understand the forms and information listed above. I also understand that my name will not be added to the University's payroll until all of the appropriate paperwork is properly completed and submitted to the Office of Human Resources.*

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(Appointee) Print Name

Date

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(Appointee) Signature

**University representative (department) contact information:**

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

Department: \_\_\_\_\_

Email: \_\_\_\_\_ Extension: \_\_\_\_\_

## HOW TO APPLY FOR A SOCIAL SECURITY CARD

Social Security Numbers are assigned to people who are authorized to work in the United States, and are used to report your wages to the government and to determine eligibility for Social Security benefits. ***You will need to apply for a Social Security Number if you have an on-campus job.***

Information needed to obtain a social security number:

- Completed application for a social security card (Form SS-5). You may download the form at [www.ssa.gov](http://www.ssa.gov);
- Your original immigration documents.
- Official “UMB Offer Letter” of employment signed by you and the employer.

To find the nearest Social Security Office go to [www.socialsecurity.gov](http://www.socialsecurity.gov) and search with your zip code.

Or call the toll free at 1-800-722-1213

### **When Can I Start Working?**

After you have submitted Form SS-5 at the Social Security Administration Office you will be given a receipt. You can begin working with the receipt. Approximately two weeks later you will receive your Social Security Card in the mail.




**PERSONAL DATA QUESTIONNAIRE**

First Name	Middle Name	Last Name	
Birth Date**	Country of Citizenship	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
<b>PLEASE ADD ADDRESS INFORMATION BELOW:</b>			
Permanent Foreign Address:			Telephone
City	Country	Postal Code	Province (Canada only)
US Address:			Telephone
City	Country	Zip Code	

\*\*If you are currently age 60 or over and starting a benefited position, you will be affected by Section 5 of Chapter 32 of the M.G.L. Please bring this fact to the attention of the Benefits Office Staff when you attend the New Employee Orientation.

<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIV/Chapter32/Section5>

Educational Data				
Educational Level	Degree	Major	School Name	Year Awarded
High School/Equivalent				
Technical Certificate				
College/University				
Master's Level Degree				
Doctorate				

**EMERGENCY CONTACTS**

	Name	Address	Telephone	Relationship
<b>PRIMARY</b>				
<b>SECONDARY</b>				

**PRIOR SERVICE IN ANY MASSACHUSETTS GOVERNMENT AGENCY**

If retired from any government agency: (CHECK)

Name of Agency	From	To

"I attest that I have read and understood all of the contents of this form and that all of the information provided on this form is correct and complete to the best of my knowledge."

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



University of Massachusetts Boston - ODEI Self-Identification Form

The University of Massachusetts Boston is an equal opportunity employer and is required by law to periodically collect and report certain data (including data on citizenship, gender and race/ethnicity, as well as disability and veteran status) regarding our faculty and staff. The information collected via this form will be entered in the University of Massachusetts Boston’s Human Resources’ information system and may be used in accordance with the applicable laws and regulations concerning equal employment opportunity.

Instructions: New hires and re-hires, please complete this form in its entirety. Current employees requesting changes, please complete all of Sections I and II and only the information you wish to update on Section III. Upon completion please return this form to the Office of Diversity, Equity and Inclusion (ODEI.) This Form will be filed separately from your personnel file.

Section I: Name and Status

Select One: [ ] New Hire/Rehire - Start Date or Effective Date of Change: \_\_\_\_\_
[ ] Current Employee - ID#: \_\_\_\_\_

Name: \_\_\_\_\_
(Last, First, Middle)

Section II: Department and Position Information

Department: \_\_\_\_\_

Position Title: \_\_\_\_\_

Position Classification: [ ] Faculty [ ] Professional [ ] Classified

Section III: Personal Information and Self-Identification (Completion of the following information is voluntary.)

Sex: [ ] Female [ ] Male

Race/Ethnicity (Please provide both):

1. Hispanic Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino

2. Racial Identity: (Please select one or more of the following racial categories)

- [ ] American Indian or Alaska Native [ ] Asian
[ ] Black or African American [ ] White
[ ] Native Hawaiian or Other Pacific Islander

Military Status (Select one): [ ] No Protected Military Service [ ] Active Duty or Wartime or Camp Badge
[ ] Armed Forces Service Medal Veteran [ ] Recently Separated Veteran
[ ] National Guard/Reserves

Disability Status: [ ] Individual with a Disability [ ] I Do Not Have a Disability
[ ] Disabled Veteran

NOTE: For accommodations, please contact the Office of Diversity, Equity and Inclusion at 617.287.4818.

Section IV: Signature and Date

SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_ [ ] I do not wish to self-Identify.

**SELF-IDENTIFICATION DEFINITIONS:** Completion of this information is voluntary. All information is confidential and will be reported in aggregate form only. Declining to provide this information will not subject you to any adverse treatment.

**Ethnicity and Race** – This two-part question is requested for statistical reporting purposes to government agencies, including the U.S. Department of Education.

- **Hispanic Ethnicity-** A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin (including Spain) regardless of race.
- **American Indian or Alaska Native -** A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.
- **Asian -** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American -** A person having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander -** A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White -** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

#### **MILITARY STATUS AND DISABILITY STATUS SELF-IDENTIFICATION**

- This information is requested for statistical reporting purposes to government agencies, including the U.S. Department of Labor. Completion of this information is voluntary. All information is confidential and will be reported in statistical form only. Declining to provide this information will not subject you to any adverse treatment. Information regarding your disability may be disclosed to the extent that (1) your supervisor(s) may be informed of any work restrictions or reasonable accommodations needed, and (2) first aid personnel may be informed when and if you require emergency medical treatment. Protected Veteran Categories:
- A **Disabled Veteran** is one of the following:
  - a. A veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or
  - b. A person who was discharged or released from active duty because of a service connected disability.
- **A Recently Separated Veteran:** Any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground naval or air service.
- **An Active Duty Wartime or Campaign Badge Veteran:** A veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- **An Armed Forces Service Medal Veteran:** A veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces Service Medal was awarded pursuant to Executive Order 12985
- **Military Discharge Date:** The date on which a person was discharged or released from military service.

## Voluntary Self-Identification of Disability

Form CC-305  
OMB Control Number 1250-0005  
Expires 1/31/2020  
Page 1 of 2

### Why are you being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities.<sup>1</sup> To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

### How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Autism
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Deafness
- Cerebral palsy
- Major depression
- Obsessive compulsive disorder
- Cancer
- HIV/AIDS
- Multiple sclerosis (MS)
- Impairments requiring the use of a wheelchair
- Diabetes
- Schizophrenia
- Missing limbs or partially missing limbs
- Intellectual disability (previously called mental retardation)
- Epilepsy
- Muscular dystrophy

Please check one of the boxes below:

- YES, I HAVE A DISABILITY (or previously had a disability)
- NO, I DON'T HAVE A DISABILITY
- I DON'T WISH TO ANSWER

\_\_\_\_\_  
Your Name

\_\_\_\_\_  
Today's Date

## Voluntary Self-Identification of Disability

Form CC-305  
OMB Control Number 1250-0005  
Expires 1/31/2020  
Page 2 of 2

### Reasonable Accommodation Notice

Federal law requires employers to provide reasonable accommodation to qualified individuals with disabilities. Please tell us if you require a reasonable accommodation to apply for a job or to perform your job. Examples of reasonable accommodation include making a change to the application process or work procedures, providing documents in an alternate format, using a sign language interpreter, or using specialized equipment.

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<sup>i</sup> Section 503 of the Rehabilitation Act of 1973, as amended. For more information about this form or the equal employment obligations of Federal contractors, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at [www.dol.gov/ofccp](http://www.dol.gov/ofccp).

**PUBLIC BURDEN STATEMENT:** According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.





**SECTION A TO BE COMPLETED BY MEMBER - SECTION B TO BE COMPLETED BY AGENCY**  
 PLEASE RETURN COMPLETED FORM TO THE MASSACHUSETTS STATE RETIREMENT BOARD

**SECTION A - TO BE COMPLETED BY MEMBER**

**1. MEMBER INFORMATION**

Name (Print) \_\_\_\_\_ Former Name \_\_\_\_\_ SSN \_\_\_\_\_

Street Address \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: M

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_ F

E-Mail \_\_\_\_\_

**Marital Status:**

Married     Single     Widowed     Divorced

If **Divorced**, are you subject to a Qualified Domestic Relations Order?  
 Yes     No

Spouse Date of Birth \_\_\_\_\_ Spouse Name \_\_\_\_\_

Are you a Veteran?  
 Yes     No

The retirement law establishes specific periods of active service, which may qualify you for certain Veteran benefits.

Start Date \_\_\_\_\_

Agency or Department \_\_\_\_\_

Agency Phone Number \_\_\_\_\_

Dates of Military Service \_\_\_\_\_

to

[A copy of your military discharge may be requested](#)

**2. PAST MEMBERSHIP HISTORY WITH ANY OTHER CONTRIBUTORY RETIREMENT SYSTEM IN MASSACHUSETTS**

Retirement System	Start Date	End Date	Was a Refund Taken?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you wish to reinstate / purchase past creditable service you must make a separate request to the State Retirement Board.

**3. ARE YOU CURRENTLY OR HAVE YOU EVER RECEIVED A RETIREMENT ALLOWANCE FROM ANOTHER PUBLIC RETIREMENT SYSTEM?**

Yes     No

**4. STATEMENT AND SIGNATURE OF MEMBER**

I certify the above information to be true and correct to the best of my knowledge and hereby accept membership in the Massachusetts State Employees' Retirement System. This statement is signed under penalties of perjury.

Member Signature \_\_\_\_\_

Date \_\_\_\_\_

*Continued on reverse*

**NEW MEMBER ENROLLMENT FORM - PAGE 2**

**SECTION A (CONTINUED)**

**5. BENEFICIARY INFORMATION**

Beneficiary or beneficiaries nominated will receive in the proportion designated any amount due at your death, if you pass away prior to retirement. The right to change any nominated beneficiary is reserved by the member.

**A beneficiary blank with corrections or erasures is not acceptable**

Give Complete Name and Address of Each Beneficiary			
Name:	Designation	Proportion*	DOB:
Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	SSN:
Name:	Designation	Proportion*	DOB:
Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	SSN:
Name:	Designation	Proportion*	DOB:
Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	SSN:
Name:	Designation	Proportion*	DOB:
Street:	<input type="checkbox"/> Primary	<input type="checkbox"/> All	Relationship:
City, State, Zip:	<input type="checkbox"/> Contingent	<input type="checkbox"/> _____ % (Percent)	SSN:

*\*Must Total 100% - If Contingent Please Specify*

**6. PLEASE SIGN BELOW**

Member Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_

**Witness may not be beneficiary**

A Change of Beneficiary Form must be used if you wish to change your designated beneficiary(ies). You may obtain this form from the State Retirement Board or [mass.gov/retirement](http://mass.gov/retirement).

**SECTION B - TO BE COMPLETED BY THE AGENCY**

Position: \_\_\_\_\_ Start Date: \_\_\_\_\_

Position: \_\_\_\_\_ Start Date: \_\_\_\_\_

State Police Start Date: \_\_\_\_\_ Date of First Deduction: \_\_\_\_\_  New  Transfer

Rate to be deducted for retirement:  5%  7%  8%  9%  12%

Service Status:  Full-Time  Part-Time \_\_\_\_\_ %  Temp/Sub \_\_\_\_\_  Other \_\_\_\_\_

Authorized Signature \_\_\_\_\_

Date \_\_\_\_\_

Agency and Payroll Number \_\_\_\_\_

## Statement Concerning Your Employment in a Job Not Covered by Social Security

**Employee Name:** \_\_\_\_\_

**Employee ID #** \_\_\_\_\_

**Employer Name:** University of Massachusetts Boston

**Employer ID#** UMS/1271

Your earnings from this job are not covered under Social Security. When you retire, or if you become disabled, you may receive a pension based on earnings from this job. If you do, and you are also entitled to a benefit from Social Security based on either your own work or the work of your husband or wife, or former husband or wife, your pension may affect the amount of the Social Security benefit you receive. Your Medicare benefits, however, will not be affected. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

### **Windfall Elimination Provision**

Under the Windfall Elimination Provision, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. As a result, you will receive a lower Social Security benefit than if you were not entitled to a pension from this job. For example, if you are age 62 in 2005, the maximum monthly reduction in your Social Security benefit as a result of this provision is \$313.50. This amount is updated annually. This provision reduces, but does not totally eliminate, your Social Security benefit. For additional information, please refer to the Social Security publication, "Windfall Elimination Provision."

### **Government Pension Offset Provision**

Under the Government Pension Offset Provision, any Social Security spouse or widow(er) benefit to which you become entitled will be offset if you also receive a Federal, State or local government pension based on work where you did not pay Social Security tax. The offset reduces the amount of your Social Security spouse or widow(er) benefit by two-thirds of the amount of your pension.

For example, if you get a monthly pension of \$600 based on earnings that are not covered under Social Security, two-thirds of that amount, \$400, is used to offset your Social Security spouse or widow(er) benefit. If you are eligible for a \$500 widow(er) benefit, you will receive \$100 per month from Social Security,  $\$500 - \$400 = \$100$ . Even if your pension is high enough to totally offset your spouse or widow(er) Social Security benefit, you are still eligible for Medicare at age 65. For additional information, please refer to the Social Security publication, "Government Pension Offset."

### **For More Information**

Social Security publications and additional information, including information about exceptions to each provision, are available at [www.socialsecurity.gov](http://www.socialsecurity.gov). You may also call toll free 1-800-772-1213, or, for the deaf or hard of hearing, call the TTY number 1-800-325-0778, or contact your local Social Security office.

**I certify that I have received Form SSA-1945 that contains information about the possible effects of the Windfall Elimination Provision and the Government Pension Offset Provision on my potential future Social Security benefits.**

**Signature of Employee** \_\_\_\_\_ **Date** \_\_\_\_\_

## **Information Regarding Social Security Form SSA-1945, Statement Concerning Your Employment in a Job Not Covered by Social Security**

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Section 419(c) of Public Law 108-203, the Social Security Protection Act of 2004 requires state and local government employers to provide a statement to employees hired January 1, 2005 or later in a job not covered under Social Security. The statement explains how a pension from that job could affect future social security benefits to which they may become entitled.

Form SSA-1945, **Statement Concerning Your Employment in a Job Not Covered by Social Security**, is the document that employers use to meet the requirements of the law. Form SSA-1945 explains the potential effects of two provisions in the social security law for employees who also receive a pension based on their work in a job not covered by Social Security. The Windfall Elimination Provision can affect the amount of an employee's social security retirement or disability benefit. The Government Pension Offset Provision can affect any possible social security benefit entitlement as a spouse or an ex-spouse.

### **FICA/Medicare Deduction**

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The Consolidated Omnibus Budget and Reconciliation Act (COBRA) which became law on April 1, 1986 mandates that all state government employees hired on or after April 1, 1986 are required to pay the Medicare portion of the Social Security tax. This tax is 1.45% of a person's annual salary. The employer is required to match the employee contribution. Regular weekly deductions will be made from the salaries of University employees subject to the Medicare deduction.

An exception to the Medicare deduction may apply to individuals who are hired by the University of Massachusetts Boston after April 1, 1986 and who are transferring from another state agency or position with continuous state service. Service at the previous state agency must have begun prior to April 1, 1986. If you feel you should be exempted from the FICA/Medicare deduction, please inform Human Resources as soon as possible.

### **Use of Social Security Numbers**

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Although the University does not deduct full social Security and does not require employee to use their social security number for identification purposes, the University reserves the right to examine an employee's social security card to verify that the name on the card matches the name being used for payroll purposes.

# DIRECT DEPOSIT

## How to Enroll:

On the bottom of your personal check, to the left side, you will locate a nine- digit Bank ID number (transit routing number) alongside these series of numbers will be your account number, WRITE CLEARLY and place these EXACT numbers on the direct deposit form. If the appointee wishes to have his/her check deposited into a savings account, he/she should contact the bank to get the Bank ID number (transit routing number) and account number

Your earnings will be electronically deposited into the bank(s) or credit union you designate (up to a maximum of four accounts) after you complete the Direct Deposit form. A pay statement detailing your earnings and deductions is available online in HR Direct.

**OR**

## GLOBAL CASH CARD PROGRAM

Employees who are experiencing hardship and/or does not submit the direct deposit form will be automatically placed on a "Global Cash Card"



### How it Works:

1. Your wages will be deposited onto the Global Cash Card Visa paycard each pay period for immediate use
2. Set up paycard alerts and two-way texting:
  - Receive email and text message alerts when your paycard is loaded on payday
  - Text and receive your paycard balance, activity, and payroll loads within seconds
3. Access your money in many ways:
  - Make signature purchases with No Fee at any merchant that accepts a Visa paycard
  - Receive cash back after making a debit purchase at many locations
  - Withdraw funds at Allpoint Network surcharge-free ATM locations

The World's Largest Surcharge-Free ATM Network. Over 60,000 surcharge-free ATM locations worldwide. Find a location near you at [www.allpointnetwork.com](http://www.allpointnetwork.com)

If you have any questions about using your Global Cash Card Paycard contact customer service at 1-949-751-0360

## GCC "No Hidden Fees" Detail

### PAYCARD PROGRAM

ENROLLMENT FEE	NO FEE
ANNUAL FEE/MONTHLY FEE	NO FEE
REWARDS PROGRAM	NO FEE
CARD REPLACEMENT	NO FEE
PIN CHANGE	NO FEE
AUTOMATED TELEPHONE	NO FEE
OPERATOR ASSISTED TELEPHONE	NO FEE
WEB SITE LOGIN	NO FEE
INACTIVITY FEE / MONTHLY	\$3.00

(AFTER NINETY (90) DAYS OF NO TRANSACTIONS – LOADS ARE TRANSACTIONS)

FIRST TRANSACTION PER PAY PERIOD	NO FEE
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### POINT OF SALE – UNITED STATES

SIGNATURE PURCHASE	NO FEE
PIN PURCHASE	NO FEE
DECLINE – SIGNATURE	\$0.80
DECLINE – PIN	\$0.50

### POINT OF SALE – OUTSIDE UNITED STATES

SIGNATURE PURCHASE	NO FEE*
PIN PURCHASE	\$1.75
DECLINE – SIGNATURE	\$1.50
DECLINE – PIN	\$1.25

\*CURRENCY CONVERSION FEE MAY APPLY

### ATM – UNITED STATES

WITHDRAWAL (ALLPOINT)	NO FEE
WITHDRAWAL (OUTSIDE OF ALLPOINT NETWORK)	\$1.75

OTHER TRANSACTIONS	\$1.00
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### ATM – OUTSIDE UNITED STATES

WITHDRAWAL	\$3.50*
OTHER TRANSACTIONS	\$3.25

### BALANCE INQUIRY

ONLINE/IVR/LIVE CUSTOMER SERVICE	NO FEE
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### MONEY TRANSFER WORLDWIDE (CARD TO CARD)

\$1 – \$2500 (DAILY LIMIT IS \$2,500)	NO FEE
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### BILL PAY

CARDHOLDER DIRECT TO MERCHANT	NO FEE
ONLINE	NO FEE
CONVENIENCE CHECK	NO FEE



# University of Massachusetts

AMHERST • BOSTON • DARTMOUTH • LOWELL • WORCESTER

## AUTHORIZATION AGREEMENT FOR EMPLOYEE DIRECT PAYROLL DEPOSIT(S)

Employee Name: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Phone: \_\_\_\_\_

### BANK INFORMATION

Deposit Priority (1) – Deducts this amount 1st	<u>Full/Deposit/Balance</u>	<input type="checkbox"/>
<input type="checkbox"/> New <input type="checkbox"/> Delete <input type="checkbox"/> Change <u>New/Amount \$</u> _____	Percentage % _____	<input type="checkbox"/>
Bank Transit/Routing# (9 digits): _____	Account Number: _____	
Bank Name: _____	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings

If depositing more than one (1) bank, you must choose one Balance Account



Deposit Priority (2) – Deducts this amount 2nd	<u>Full/Deposit/Balance</u>	<input type="checkbox"/>
<input type="checkbox"/> New <input type="checkbox"/> Delete <input type="checkbox"/> Change <u>New/Amount \$</u> _____	Percentage % _____	<input type="checkbox"/>
Bank Transit/Routing # (9 digits): _____	Account Number: _____	
Bank Name: _____	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings

Deposit Priority (3) – Deducts this amount 3rd	<u>Full/Deposit/Balance</u>	<input type="checkbox"/>
<input type="checkbox"/> New <input type="checkbox"/> Delete <input type="checkbox"/> Change <u>New/Amount \$</u> _____	Percentage % _____	<input type="checkbox"/>
Bank Transit/Routing # (9 digits): _____	Account Number: _____	
Bank Name: _____	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings

Deposit Priority (4) – Deducts this amount 4th	<u>Full/Deposit/Balance</u>	<input type="checkbox"/>
<input type="checkbox"/> New <input type="checkbox"/> Delete <input type="checkbox"/> Change <u>New/Amount \$</u> _____	Percentage % _____	<input type="checkbox"/>
Bank Transit/Routing # (9 digits): _____	Account Number: _____	
Bank Name: _____	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings

I hereby authorize the University of Massachusetts to deposit my net pay as indicated above at the financial institution(s) named above. I understand the University of Massachusetts may cause my account to be adjusted to the extent necessary to correct any over deposit and I agree to hold the above named financial institution(s) harmless for any erroneous deposits or adjustments not caused by the financial institution. It is understood that I may terminate this agreement at any time by written notification to the University of Massachusetts. Any such notification to the University of Massachusetts shall be effective only with respect to entries initiated by the University after receipt of such notification and reasonable opportunity to act upon it. Any such notification to the bank by the employee is unacceptable. The bank may terminate this agreement by written notice to the employee for just cause.

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

HUMAN RESOURCES USE ONLY:



## MEMORANDUM

**To:** UMass Boston Staff and Faculty  
**From:** Marie H. Bowen, Assistant Vice Chancellor for Human Resources  
**Date:** April 27, 2017  
**Subject:** **Annual Notice - Conflict of Interest Law Education Requirements**

The conflict of interest law seeks to prevent conflicts between private interests and public duties, foster integrity in public service, and promote the public's trust and confidence in that service by placing restrictions on what employees of the university may do on the job, after hours, and after leaving public service.

Annual conflict of interest law education and training is mandated by the University of Massachusetts Boston and the Commonwealth of Massachusetts, which requires that all employees complete the training every two (2) years. New employees should complete the training within thirty (30) days of the date of hire.

To ensure compliance with the Conflict of Interest requirements, please complete the following steps.

1. Acknowledge Receipt of the Summary of the Conflict of Interest Law for State Employees:

The summary of the conflict of interest law, General Laws chapter 268A, is intended to help employees understand how that law applies to them. The summary is not a substitute for legal advice, nor does it mention every aspect of the law that may apply in a particular situation.

The law requires that this form, which may be accessed at <https://www.mass.gov/service-details/summary-of-the-conflict-of-interest-law-for-state-employees> be submitted annually

Please print and sign the form and return it to Sandra Knight, Human Resources.

2. Complete the Conflict of Interest Law Online Training Program:

The training program covers various issues you may encounter as a public employee and provides examples and reference information to help you recognize conflicts of interest. Recognizing and properly responding to a conflict of interest is a key element to maintaining the public's confidence in government and in the integrity of the work we do as public employees.

The training program can be found at: <https://www.mass.gov/how-to/complete-the-online-training-program-for-state-and-county-employees>.

Click "Online Program for State and County Employees". The training should take approximately one (1) hour to complete.

Upon completion of the training you will have the ability to print a Certificate of Completion. Please do so, make a copy for your records and send the certificate to Sandra Knight, Human Resources. **You must complete the entire training in order to receive a certificate.**

NOTE: The online training program is not compatible with the Google Chrome web browser and make sure to disable pop-up blockers.

If you have questions, please review the [Education and Training Guidelines](#) available on the State Ethics Commission's website, [www.mass.gov/ethics](http://www.mass.gov/ethics). The guidelines provide helpful information about who is required to comply with these statutory requirements, record-keeping requirements, and the process.

Thank you for your time and attention to this important matter. If you have any questions, please contact Sandra Knight in Human Resources at [Sandra.Knight@umb.edu](mailto:Sandra.Knight@umb.edu).





# GLACIER

Nonresident Alien Tax Compliance System


Click on the Image Above to Enter GLACIER  
or [Login Now](#)

GLACIER supports [Internet Explorer](#), [FireFox](#) (On Windows or MAC platforms), and Apple Safari.  
Javascript must be enabled to use GLACIER.

Please direct any questions about using GLACIER to: [support@online-tax.net](mailto:support@online-tax.net)

GLACIER is a product of Arctic International LLC.  
For more information about other Nonresident Alien Tax Compliance Products and  
Services visit [www.arcticintl.com](http://www.arcticintl.com)

A link will be sent to the email address we have on file for you prior to your start date from [support@online-tax.net](mailto:support@online-tax.net). You must log in and follow the instructions to complete a tax summary and once completed print, sign and date the form and submit the required documents to Human Resources.

<b>GLACIER</b>	Nonresident Alien Tax Compliance	
<b>Welcome to GLACIER Nonresident Alien Tax Compliance</b>		
<b>To access GLACIER, please enter the following information:</b>		
UserID:	<input type="text"/>	
Password:	<input type="password"/>	
<a href="#">Forgot Login?</a>	If you have forgotten your UserID and/or Password, please select <b>Forgot Login?</b> An email will be sent to the email address in your <b>GLACIER</b> Individual Record.	
<small>GLACIER supports Internet Explorer, FireFox (On Windows or MAC platforms), and Apple Safari. Javascript must be enabled to use GLACIER. Please direct any questions about using GLACIER to: <a href="mailto:support@online-tax.net">support@online-tax.net</a> GLACIER is a product of Arctic International LLC</small>		
<input type="submit" value="Submit"/>		

If you need instructions on completing the Federal Tax Form (W4) visit <https://hr.umb.edu/forms#17-taxes>.

If you need further assistance or questions in the completion of the tax documents please contact [Quan.Tran@umb.edu](mailto:Quan.Tran@umb.edu).

If you are experiencing any system related issues please contact Glacier at [support@online-tax.net](mailto:support@online-tax.net).



DISCLOSURE OF NAMES OF FAMILY MEMBERS WHO ARE STATE EMPLOYEES

Disclosure Required by G.L. c. 268A, Sec. 6B

Name of Applicant for Employment: \_\_\_\_\_

Date: \_\_\_\_\_

Is your spouse, parent, brother, sister or child, or the spouse of your parent, brother, sister or child, a state employee?

\_\_\_ Yes \_\_\_ No

If you answered Yes, please list below the name(s) of any state employee who is your spouse, parent, brother, sister or child, or who is the spouse of your parent, brother, sister or child, and indicate their relationship to you. Please also list the name of the state agency that employs those relatives.

NOTE: For purposes of this disclosure, a "state employee" is a person holding a paid or unpaid office, position, employment or membership in a Massachusetts state agency. For purposes of this disclosure, a "state agency" is any department of Massachusetts state government, including any department or agency within the executive, legislative or judicial branch, and all councils thereof and thereunder, and any division, board, bureau, commission, institution, tribunal or other instrumentality within such department or agency, and any independent state authority, commission, instrumentality or agency, but NOT INCLUDING an agency of a county, city or town.

Name of Relative Relationship to Applicant Name of State Agency

Table with 3 columns: Name of Relative, Relationship to Applicant, Name of State Agency. Multiple rows of blank lines for data entry.



## Computer and System Usage

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As an employee of the University of Massachusetts (the University), I understand that the unauthorized use or misuse of University computer facilities, computer applications, computer systems, and/or electronic communications systems (including e-mail) constitutes an infraction of the University's data and computing policies/guidelines.

I will not share or release any logon, operator id or password used to access University data, computer systems, or electronic communications systems. I will keep my password(s) confidential, will change my password as required by the computer system and will select a password that is difficult to guess. I will not store access passwords in batch files, in automatic login scripts, in terminal function keys, in computers without access control or in other locations where another person might discover them.

I will not intentionally write, produce, generate, copy, propagate or attempt to introduce a computer virus, worm, Trojan horse, etc. into any University computer system or any computers linked to the University computer system.

I further acknowledge that I will not use University data or computing systems (e.g. software, hardware, network components, etc.) in any illegal, unethical or unauthorized commercial activities.

## Data Confidentiality

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I recognize my individual responsibility for safeguarding the integrity, accuracy and confidentiality of data that I access as dictated by state and federal law, and University policies and procedures.

I will not improperly release any information obtained as a result of my authorized access.

I will properly create, access, use and dispose of University data based on the data's classification.

## Software Usage

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I will not knowingly violate the terms of University license agreements for software. I recognize that the University licenses the use of commercial software and does not own this software or its related documentation or instructional material, and except to the extent authorized by the software developer, does not have the right to copy computer software. I will use documentation only as allowed by the vendor and federal Copyright law.

I will not use personally owned software in University computers unless I have a proper license for the software and the license authorizes such use. I will only use such personally owned software in University computers after I have first obtained clearance from appropriate systems personnel as to its compatibility with University computers and systems.

I will not illegally distribute copyrighted software within or outside the University through any mechanism, electronic or otherwise. I will not use my e-mail access to unlawfully solicit or exchange copies of copyrighted software.

*(1) As directed by Board of Trustees' Policy Statements on Electronic Data Security, Electronic Mail and Computer Policy Development (Doc. T97-010, adopted February 5, 1997), and Policy Statement on Record Management, Retention and Disposition (Doc. T99-061 adopted August 4, 1999). Full text of these Policies and related Guidelines and all University Data and Computing Guidelines can be found at: <https://www.umassp.edu/bot/policies>*





## Electronic Communications

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I will use e-mail and any other electronic communications tool in a responsible manner consistent with other business communications (e.g., phone, correspondence). I will safeguard the integrity and confidentiality of University electronic mail; only use mail IDs assigned to me and will remove mail from my mailbox consistent with University, campus, departmental or electronic mail administrator message retention procedures.

I will not "rebroadcast"/send to a third party information obtained from another individual that the individual reasonably expects to be confidential, except as required by my job responsibilities, University policies and procedures, and applicable law.

I will not post materials that violate existing laws or University policies/codes of conduct. For example, materials that are of a fraudulent, defamatory, harassing, or threatening nature. I will not unnecessarily or inappropriately use computer resources by sending chain e-mails, spamming, mail bombing, generating unnecessary excessive print, etc.

## My Responsibilities

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I have agreed and will attend a workshop that includes information regarding my computer security and data confidentiality responsibilities as an employee of the University. I understand these responsibilities both as an authorized user and an employee.

I recognize my overall responsibility to exercise the degree of care required to maintain control of University computing systems and resources (e.g., data, software, hardware, network components, etc.) and agree to abide by established University policies/guidelines and Campus procedures. I acknowledge that failure to comply with University data and computing related policies/guidelines/procedures might result in: the loss or restriction of my computer access; reprimand; suspension; dismissal, or other disciplinary or legal action.

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*Print Name*

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*Signature*

*Date*

