

Catherine L. Szpindor

Chief Administrative Officer

Office of the
Chief Administrative Officer
U.S. House of Representatives
Washington, DC 20515-6860

U.S. House of Representatives Employee On-Boarding

This cover page is intended to facilitate the online completion of these forms using Adobe Reader. The personal information typed on this page will populate into corresponding fields on each applicable page. *We strongly recommend using Adobe Reader to complete the forms because it will save you time and effort* and provide the option to print only the pages required to receive a paycheck and benefits or the entire packet with instructions.

Pages 6 -7, 9, 14, 17, 19, 21-22, along with 28-29 are required for a complete Appointment package. Page 24 is a benefit form that does not need to be completed on the date of hire but will require action by the employee by a certain deadline (see page 23).

NAME

First

Middle

Last

Social Security Number

Date of Birth

Enter DATE in format: MM/DD/YYYY

Address Line 1

Address Line 2

City

State Maryland

Zipcode

Home Phone Number

Daytime Phone Number

Office Phone Number

Employing Office Name

Enter PHONE
Numbers in format:
0123456789

Effective Date of Appointment

Today's Date

A Payroll Authorization Form (PAF), signed by the Member or Chairman, must accompany this packet. The PAF Smartform may be found on:

[HouseNet >Forms >Payroll Authorization Form \(Smart Form\).](#)

Please remember to sign ALL forms!

Welcome TO THE HOUSE

We hope this reference guide from the Office of the Chief Administrative Officer (CAO) helps you to find the services you need.

Got questions? Need answers?

If you don't know where to turn or who to call, search HouseNet or contact First Call. First Call staffers will be able to find an answer to any of your questions. First Call also provides passport services and room scheduling for conferences and meetings. Contact First Call at **202-225-8000**.

Need Technical or Cybersecurity Help?

Contact the Technology Service Desk at **202-225-6002**. Technical assistance is available 24/7. Also, call if you have any concerns about email phishing attacks or hacking attempts.

Payroll and Benefits

For questions about your paycheck or health and benefits coverage, call **202-225-1435** or visit at Longworth B-215.

Counseling and Well-Being Services

Call the Office of Employee Assistance at **202-225-4000** for help with personal, behavioral, substance abuse, and stress-related difficulties. Counseling is free and confidential. The House Wellness Center also offers a comprehensive well-being program for House staff. Visit, WellnessCenter.house.gov to learn more.

Food Services

There are three cafeterias, a Dunkin' Donuts, Subway, Au Bon Pain, Steak 'n Shake, and Jamba in House Office Buildings. Additionally, there are vending areas and snack and beverage markets. Check HouseNet for menus and locations.

Personal Services

The House Campus hosts many personal services such as a fitness center, barbershop, dry cleaner, child care, and more. Information about each can be found on HouseNet under the Campus tab.

Office Supply and Gifts

Supplies for your office or gifts for friends can be found in the Office Supply Store and Gift Shop. They are located next to each other in Longworth B-217 & B-218.

Note: Some of the services described in this document may be impacted by the current operating status of the House due to the ongoing COVID-19 pandemic. Please check HouseNet for the latest information on the availability of these services.

Websites



HouseNet.house.gov



CAO.house.gov



WellnessCenter.house.gov

Social Media

Stay up to date, follow the CAO



[@CAOHouse](https://www.facebook.com/CAOHouse)



[Facebook.com/CAOHouseofReps](https://www.facebook.com/CAOHouseofReps)



[@HouseCreativeServices](https://twitter.com/HouseCreativeServices)

Important Phone Numbers



First Call

202-225-8000



Technology Service Desk

202-225-6002



Payroll and Benefits

202-225-1435



Office of Employee Assistance

202-225-4000

House Alert

Sign up for the emergency communication system



alert.house.gov



CAO
CHIEF ADMINISTRATIVE OFFICER

REQUIRED TRAINING FOR HOUSE EMPLOYEES

Workplace Rights and Responsibilities Education Training

Each Member, Officer, and employee (including staff, paid and unpaid interns, fellows, and detailees) of the House of Representatives must complete an education program in Workplace Rights and Responsibilities each session of each Congress.

- This annual session must be completed within 90 days of House employment. Visit the Congressional Staff Academy website at <https://house.csod.com/samldefault.aspx> and select Workplace Rights & Responsibilities Training under Required Training on the righthand navigation bar.

For more information or questions regarding the Workplace Rights and Responsibilities Education requirement, please contact the Workplace Rights Hotline at 202-225-9500 or WorkplaceRights@mail.house.gov.

Ethics Training

The Committee on Ethics is responsible for providing annual ethics training to all House Members, Officers, and employees.

New Employees

- All new employees must complete the annual training within the first 60 days of House employment.
- New employees who work in the Capitol Hill offices must attend a live ethics training briefing. View <https://ethics.house.gov/legislation/schedule/new-employee> for a training schedule and registration information.
- New employees in the district may complete online training. Visit <https://HouseNet.house.gov/EthicsTraining> for registration information.

Senior Staff*

- New senior staff must complete new employee ethics training within 60 days of beginning House employment (see above) and complete a second hour of specialized “senior staff” training before the end of the current Congress.
- There are two options for fulfilling the specialized “senior staff” training requirement:
 1. Watch the *Senior Staff* video available on the Congressional Staff Academy website. Visit <https://HouseNet.house.gov/EthicsTraining> for registration information; or
 2. Attend a live *Senior Staff*, or *Financial Disclosure*, or *Periodic Transaction Report* training session. Visit <https://ethics.house.gov/legislation/schedule/senior-staff> for a training schedule and registration information.

* The definition of “senior staff” may be found at <https://ethics.house.gov/legislation/schedule/senior-staff>.

Cybersecurity Training

House policy requires that all individuals who have access to the House network complete Cybersecurity Training once a year.

- You must complete the annual training within 30 days from issuance of Active Directory credentials (House account login). To complete the training, visit <https://HouseNet.house.gov/CyberTraining> where you will find instructions and a secure link to the external training website.

For questions, please email CyberTraining@mail.house.gov or call 202-226-1513.

Instructions for Employment Eligibility Requirements and Form I-9

Employment Eligibility Verification

- **Note:** The Employment Eligibility requirement is a separate and additional requirement from the Form I-9 Employment Eligibility Verification (DHS & USCIS) and documentation requirements. Both 1 & 2 **MUST** be fulfilled for a complete Appointment package.

- 1. Employment Eligibility Requirements: Required with all new hire Appointment packages**
 - **U.S. Citizen** – The Employment Eligibility process requires that a prospective employee provide one of the documents listed in the Employment Eligibility Requirements with their completed Appointment package to prove the prospective employee is a U.S. Citizen.
 - **Non - U.S. Citizen** – The Employment Eligibility process requires that a prospective Non-U.S. Citizen employee provide one of the documents listed in the Employment Eligibility Requirements with a completed Appointment package to meet employment eligibility requirements.
 - Questions on Non-U.S. Citizen requirements or notarized affidavits should be directed to the Office of General Counsel at 202-225-9700.

- 2. Form I-9 Employment Eligibility Verification (DHS & USCIS): Required with all new hire Appointment packages**
 - Form I-9 is to be completed by prospective employee and certified by employing office:
 - Section 1 completed by employee, sections 2 and 3 to be completed by your employing office.
 - If a List A document is used on prospective employee's Form I-9, a color copy of the document must be submitted with the Form I-9 to meet photo matching requirements.
 - Effective 05-16-2014, the CAO Office of Payroll & Benefits will run new hire's completed Form I-9 through the Department of Homeland Security's E-Verify System to verify employment eligibility in the United States for all new hires. Offices will no longer have the option to use the Department of Homeland Security's E-Verify System themselves.
 - Effective 05-16-2014, Completed Appointment packages must be submitted to the Office of Payroll & Benefits **two business days prior** to effective date of hire.

Documents for Employment Eligibility Verification Requirements

United States Citizens

Provide proof of the prospective employee's United States Citizenship via either:

- a.** a photocopy of an original or certified copy of birth certificate bearing an official seal; **or**
- b.** a color copy of United States Passport or Passport Card; **or**
- c.** a photocopy of naturalization certificate; **or**
- d.** a photocopy of a certificate of citizenship.

Non-U.S. Citizens

Provide a signed, notarized affidavit by the prospective employee attesting that he/she satisfies any **one** of the following categories:

- e.** The prospective employee is a lawfully admitted permanent resident **and** is seeking citizenship within the timing requirements of 8 U.S.C. § 1324b(a)(3)(B). Under this option, a prospective employee must attach to the affidavit proof of lawful permanent residency;
- f.** The prospective employee has been admitted as a refugee under 8 U.S.C. § 1157, and has filed a declaration of intention to become a lawful permanent resident and then a citizen when eligible. Under this option, a prospective employee must attach to the affidavit proof of admission as a refugee;
- g.** The prospective employee has been granted asylum under 8 U.S.C. § 1158, and intends to become a lawful permanent resident and then a citizen when eligible. Under this option, a prospective employee must attach to the affidavit proof of the grant of asylum; or
- h.** The prospective employee is a person who owes allegiance to the United States. A person who owes allegiance to the United States is generally defined as one who is a national of American Samoa, the Swains Island, or the Northern Mariana Islands, and nationals who meet other requirements described in 8 U.S.C. §1408.



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

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

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

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

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

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

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

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

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i>	
1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date (mm/dd/yyyy)
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Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

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

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



Employer Completes Next Page





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

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

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		<div>Additional Information</div> <div>QR Code - Sections 2 & 3 Do Not Write In This Space</div>		
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

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

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

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative		First Name of Employer or Authorized Representative	Employer's Business or Organization Name US House of Representatives	
Employer's Business or Organization Address (Street Number and Name) B215 Longworth House Office Building		City or Town Washington	State DC	ZIP Code 20515

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

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

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

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

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

All documents must be UNEXPIRED

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

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

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

Refer to the instructions for more information about acceptable receipts.

U.S. HOUSE OF REPRESENTATIVES NEW HIRE HEALTH DESIGNATION FORM

NOTE: This form is to be signed by the Employing Authority and submitted with the appointment payroll authorization form (PAF) to designate an Employee's health care eligibility. Therefore, if this form is not turned in with the PAFs, the Employing Authority is delegating their authority to the Chief Administrative Office to determine health care eligibility.

FROM:

(Employing Office)

TO:

THE CHIEF ADMINISTRATIVE OFFICER OF THE HOUSE

I have determined that the below employee, whom I hired on _____,

☐

DOES meet the definition of "congressional staff" in 5 C.F.R. § 890.101. (DC Health Link)

☐

DOES NOT meet the definition of "congressional staff" in 5 C.F.R. § 890.101. (FEHBP)

SOCIAL SECURITY NUMBER (Employee Number if current employee)	LAST NAME	FIRST NAME

OR

☐

I delegate my authority to the Chief Administrative Officer to determine whether _____, whom I hired on _____, meets the definition of "congressional staff" in 5 C.F.R. § 890.101. I understand that the Chief Administrative Officer will designate the individual as "congressional staff" if they are paid exclusively from the MRA(s).

(Date)

(Signature of Employing Authority)

(Type or print name of Employing Authority)

Employee's Withholding Certificate

OMB No. 1545-0074

2021

- ▶ **Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.**
▶ **Give Form W-4 to your employer.**
▶ **Your withholding is subject to review by the IRS.**

Step 1:
Enter
Personal
Information

(a) First name and middle initial	Last name	(b) Social security number
Address		▶ Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
City or town, state, and ZIP code		
(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying widow(er) <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, when to use the estimator at www.irs.gov/W4App, and privacy.

Step 2:
Multiple Jobs
or Spouse
Works

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

Do **only one** of the following.

- (a) Use the estimator at www.irs.gov/W4App for most accurate withholding for this step (and Steps 3–4); **or**
 (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below for roughly accurate withholding; **or**
 (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld ▶ ☐

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

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

Step 3:
Claim
Dependents

If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly):

Multiply the number of qualifying children under age 17 by \$2,000 ▶ \$ _____

Multiply the number of other dependents by \$500 ▶ \$ _____

Add the amounts above and enter the total here **3** \$ _____

Step 4
(optional):
Other
Adjustments

(a) **Other income (not from jobs).** If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income **4(a)** \$ _____

(b) **Deductions.** If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here **4(b)** \$ _____

(c) **Extra withholding.** Enter any additional tax you want withheld each pay period **4(c)** \$ _____

Step 5:
Sign
Here

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

▶ **Employee's signature** (This form is not valid unless you sign it.) ▶ **Date**

Employers
Only

Employer's name and address	First date of employment	Employer identification number (EIN)
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General Instructions

Future Developments

For the latest information about developments related to Form W-4, such as legislation enacted after it was published, go to www.irs.gov/FormW4.

Purpose of Form

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. If too little is withheld, you will generally owe tax when you file your tax return and may owe a penalty. If too much is withheld, you will generally be due a refund. Complete a new Form W-4 when changes to your personal or financial situation would change the entries on the form. For more information on withholding and when you must furnish a new Form W-4, see Pub. 505, Tax Withholding and Estimated Tax.

Exemption from withholding. You may claim exemption from withholding for 2021 if you meet both of the following conditions: you had no federal income tax liability in 2020 **and** you expect to have no federal income tax liability in 2021. You had no federal income tax liability in 2020 if (1) your total tax on line 24 on your 2020 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, 29, and 30), or (2) you were not required to file a return because your income was below the filing threshold for your correct filing status. If you claim exemption, you will have no income tax withheld from your paycheck and may owe taxes and penalties when you file your 2021 tax return. To claim exemption from withholding, certify that you meet both of the conditions above by writing "Exempt" on Form W-4 in the space below Step 4(c). Then, complete Steps 1(a), 1(b), and 5. Do not complete any other steps. You will need to submit a new Form W-4 by February 15, 2022.

Your privacy. If you prefer to limit information provided in Steps 2 through 4, use the online estimator, which will also increase accuracy.

As an alternative to the estimator: if you have concerns with Step 2(c), you may choose Step 2(b); if you have concerns with Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c). If this is the only job in your household, you may instead check the box in Step 2(c), which will increase your withholding and significantly reduce your paycheck (often by thousands of dollars over the year).

When to use the estimator. Consider using the estimator at www.irs.gov/W4App if you:

1. Expect to work only part of the year;
2. Have dividend or capital gain income, or are subject to additional taxes, such as Additional Medicare Tax;
3. Have self-employment income (see below); or
4. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at www.irs.gov/W4App to figure the amount to have withheld.

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

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

If you (and your spouse) have a total of only two jobs, you may instead check the box in option **(c)**. The box must also be checked on the Form W-4 for the other job. If the box is checked, the standard deduction and tax brackets will be cut in half for each job to calculate withholding. This option is roughly accurate for jobs with similar pay; otherwise, more tax than necessary may be withheld, and this extra amount will be larger the greater the difference in pay is between the two jobs.



Multiple jobs. Complete Steps 3 through 4(b) on only one Form W-4. Withholding will be most accurate if you do this on the Form W-4 for the highest paying job.

Step 3. This step provides instructions for determining the amount of the child tax credit and the credit for other dependents that you may be able to claim when you file your tax return. To qualify for the child tax credit, the child must be under age 17 as of December 31, must be your dependent who generally lives with you for more than half the year, and must have the required social security number. You may be able to claim a credit for other dependents for whom a child tax credit can't be claimed, such as an older child or a qualifying relative. For additional eligibility requirements for these credits, see Pub. 972, Child Tax Credit and Credit for Other Dependents. You can also include **other tax credits** in this step, such as education tax credits and the foreign tax credit. To do so, add an estimate of the amount for the year to your credits for dependents and enter the total amount in Step 3. Including these credits will increase your paycheck and reduce the amount of any refund you may receive when you file your tax return.

Step 4 (optional).

Step 4(a). Enter in this step the total of your other estimated income for the year, if any. You shouldn't include income from any jobs or self-employment. If you complete Step 4(a), you likely won't have to make estimated tax payments for that income. If you prefer to pay estimated tax rather than having tax on other income withheld from your paycheck, see Form 1040-ES, Estimated Tax for Individuals.

Step 4(b). Enter in this step the amount from the Deductions Worksheet, line 5, if you expect to claim deductions other than the basic standard deduction on your 2021 tax return and want to reduce your withholding to account for these deductions. This includes both itemized deductions and other deductions such as for student loan interest and IRAs.

Step 4(c). Enter in this step any additional tax you want withheld from your pay **each pay period**, including any amounts from the Multiple Jobs Worksheet, line 4. Entering an amount here will reduce your paycheck and will either increase your refund or reduce any amount of tax that you owe.

Step 2(b)—Multiple Jobs Worksheet (Keep for your records.)

If you choose the option in Step 2(b) on Form W-4, complete this worksheet (which calculates the total extra tax for all jobs) on **only ONE** Form W-4. Withholding will be most accurate if you complete the worksheet and enter the result on the Form W-4 for the highest paying job.

Note: If more than one job has annual wages of more than \$120,000 or there are more than three jobs, see Pub. 505 for additional tables; or, you can use the online withholding estimator at www.irs.gov/W4App.

- 1 Two jobs.** If you have two jobs or you're married filing jointly and you and your spouse each have one job, find the amount from the appropriate table on page 4. Using the "Higher Paying Job" row and the "Lower Paying Job" column, find the value at the intersection of the two household salaries and enter that value on line 1. Then, **skip** to line 3 **1** \$ _____
- 2 Three jobs.** If you and/or your spouse have three jobs at the same time, complete lines 2a, 2b, and 2c below. Otherwise, skip to line 3.
 - a** Find the amount from the appropriate table on page 4 using the annual wages from the highest paying job in the "Higher Paying Job" row and the annual wages for your next highest paying job in the "Lower Paying Job" column. Find the value at the intersection of the two household salaries and enter that value on line 2a **2a** \$ _____
 - b** Add the annual wages of the two highest paying jobs from line 2a together and use the total as the wages in the "Higher Paying Job" row and use the annual wages for your third job in the "Lower Paying Job" column to find the amount from the appropriate table on page 4 and enter this amount on line 2b **2b** \$ _____
 - c** Add the amounts from lines 2a and 2b and enter the result on line 2c **2c** \$ _____
- 3** Enter the number of pay periods per year for the highest paying job. For example, if that job pays weekly, enter 52; if it pays every other week, enter 26; if it pays monthly, enter 12, etc. **3** _____
- 4 Divide** the annual amount on line 1 or line 2c by the number of pay periods on line 3. Enter this amount here and in **Step 4(c)** of Form W-4 for the highest paying job (along with any other additional amount you want withheld) **4** \$ _____

Step 4(b)—Deductions Worksheet (Keep for your records.)

- 1** Enter an estimate of your 2021 itemized deductions (from Schedule A (Form 1040)). Such deductions may include qualifying home mortgage interest, charitable contributions, state and local taxes (up to \$10,000), and medical expenses in excess of 7.5% of your income **1** \$ _____
- 2** Enter: $\left\{ \begin{array}{l} \bullet \$25,100 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \$18,800 \text{ if you're head of household} \\ \bullet \$12,550 \text{ if you're single or married filing separately} \end{array} \right\}$ **2** \$ _____
- 3** If line 1 is greater than line 2, subtract line 2 from line 1 and enter the result here. If line 2 is greater than line 1, enter "-0-" **3** \$ _____
- 4** Enter an estimate of your student loan interest, deductible IRA contributions, and certain other adjustments (from Part II of Schedule 1 (Form 1040)). See Pub. 505 for more information **4** \$ _____
- 5 Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 **5** \$ _____

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person with no other entries on the form; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

Married Filing Jointly or Qualifying Widow(er)

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$190	\$850	\$890	\$1,020	\$1,020	\$1,020	\$1,020	\$1,020	\$1,100	\$1,870	\$1,870
\$10,000 - 19,999	190	1,190	1,890	2,090	2,220	2,220	2,220	2,220	2,300	3,300	4,070	4,070
\$20,000 - 29,999	850	1,890	2,750	2,950	3,080	3,080	3,080	3,160	4,160	5,160	5,930	5,930
\$30,000 - 39,999	890	2,090	2,950	3,150	3,280	3,280	3,360	4,360	5,360	6,360	7,130	7,130
\$40,000 - 49,999	1,020	2,220	3,080	3,280	3,410	3,490	4,490	5,490	6,490	7,490	8,260	8,260
\$50,000 - 59,999	1,020	2,220	3,080	3,280	3,490	4,490	5,490	6,490	7,490	8,490	9,260	9,260
\$60,000 - 69,999	1,020	2,220	3,080	3,360	4,490	5,490	6,490	7,490	8,490	9,490	10,260	10,260
\$70,000 - 79,999	1,020	2,220	3,160	4,360	5,490	6,490	7,490	8,490	9,490	10,490	11,260	11,260
\$80,000 - 99,999	1,020	3,150	5,010	6,210	7,340	8,340	9,340	10,340	11,340	12,340	13,260	13,460
\$100,000 - 149,999	1,870	4,070	5,930	7,130	8,260	9,320	10,520	11,720	12,920	14,120	15,090	15,290
\$150,000 - 239,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,230	16,190	16,400
\$240,000 - 259,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,830	14,030	15,270	17,040	18,040
\$260,000 - 279,999	2,040	4,440	6,500	7,900	9,230	10,430	11,630	12,870	14,870	16,870	18,640	19,640
\$280,000 - 299,999	2,040	4,440	6,500	7,900	9,230	10,470	12,470	14,470	16,470	18,470	20,240	21,240
\$300,000 - 319,999	2,040	4,440	6,500	7,940	10,070	12,070	14,070	16,070	18,070	20,070	21,840	22,840
\$320,000 - 364,999	2,720	5,920	8,780	10,980	13,110	15,110	17,110	19,110	21,190	23,490	25,560	26,860
\$365,000 - 524,999	2,970	6,470	9,630	12,130	14,560	16,860	19,160	21,460	23,760	26,060	28,130	29,430
\$525,000 and over	3,140	6,840	10,200	12,900	15,530	18,030	20,530	23,030	25,530	28,030	30,300	31,800

Single or Married Filing Separately

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$440	\$940	\$1,020	\$1,020	\$1,410	\$1,870	\$1,870	\$1,870	\$1,870	\$2,030	\$2,040	\$2,040
\$10,000 - 19,999	940	1,540	1,620	2,020	3,020	3,470	3,470	3,470	3,640	3,840	3,840	3,840
\$20,000 - 29,999	1,020	1,620	2,100	3,100	4,100	4,550	4,550	4,720	4,920	5,120	5,120	5,120
\$30,000 - 39,999	1,020	2,020	3,100	4,100	5,100	5,550	5,720	5,920	6,120	6,320	6,320	6,320
\$40,000 - 59,999	1,870	3,470	4,550	5,550	6,690	7,340	7,540	7,740	7,940	8,140	8,150	8,150
\$60,000 - 79,999	1,870	3,470	4,690	5,890	7,090	7,740	7,940	8,140	8,340	8,540	9,190	9,990
\$80,000 - 99,999	2,000	3,810	5,090	6,290	7,490	8,140	8,340	8,540	9,390	10,390	11,190	11,990
\$100,000 - 124,999	2,040	3,840	5,120	6,320	7,520	8,360	9,360	10,360	11,360	12,360	13,410	14,510
\$125,000 - 149,999	2,040	3,840	5,120	6,910	8,910	10,360	11,360	12,450	13,750	15,050	16,160	17,260
\$150,000 - 174,999	2,220	4,830	6,910	8,910	10,910	12,600	13,900	15,200	16,500	17,800	18,910	20,010
\$175,000 - 199,999	2,720	5,320	7,490	9,790	12,090	13,850	15,150	16,450	17,750	19,050	20,150	21,250
\$200,000 - 249,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$250,000 - 399,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,820	20,930	22,030
\$400,000 - 449,999	2,970	5,880	8,260	10,560	12,860	14,620	15,920	17,220	18,520	19,910	21,220	22,520
\$450,000 and over	3,140	6,250	8,830	11,330	13,830	15,790	17,290	18,790	20,290	21,790	23,100	24,400

Head of Household

Higher Paying Job Annual Taxable Wage & Salary	Lower Paying Job Annual Taxable Wage & Salary											
	\$0 - 9,999	\$10,000 - 19,999	\$20,000 - 29,999	\$30,000 - 39,999	\$40,000 - 49,999	\$50,000 - 59,999	\$60,000 - 69,999	\$70,000 - 79,999	\$80,000 - 89,999	\$90,000 - 99,999	\$100,000 - 109,999	\$110,000 - 120,000
\$0 - 9,999	\$0	\$820	\$930	\$1,020	\$1,020	\$1,020	\$1,420	\$1,870	\$1,870	\$1,910	\$2,040	\$2,040
\$10,000 - 19,999	820	1,900	2,130	2,220	2,220	2,620	3,620	4,070	4,110	4,310	4,440	4,440
\$20,000 - 29,999	930	2,130	2,360	2,450	2,850	3,850	4,850	5,340	5,540	5,740	5,870	5,870
\$30,000 - 39,999	1,020	2,220	2,450	2,940	3,940	4,940	5,980	6,630	6,830	7,030	7,160	7,160
\$40,000 - 59,999	1,020	2,470	3,700	4,790	5,800	7,000	8,200	8,850	9,050	9,250	9,380	9,380
\$60,000 - 79,999	1,870	4,070	5,310	6,600	7,800	9,000	10,200	10,850	11,050	11,250	11,520	12,320
\$80,000 - 99,999	1,880	4,280	5,710	7,000	8,200	9,400	10,600	11,250	11,590	12,590	13,520	14,320
\$100,000 - 124,999	2,040	4,440	5,870	7,160	8,360	9,560	11,240	12,690	13,690	14,690	15,670	16,770
\$125,000 - 149,999	2,040	4,440	5,870	7,240	9,240	11,240	13,240	14,690	15,890	17,190	18,420	19,520
\$150,000 - 174,999	2,040	4,920	7,150	9,240	11,240	13,290	15,590	17,340	18,640	19,940	21,170	22,270
\$175,000 - 199,999	2,720	5,920	8,150	10,440	12,740	15,040	17,340	19,090	20,390	21,690	22,920	24,020
\$200,000 - 249,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$250,000 - 349,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,880	24,980
\$350,000 - 449,999	2,970	6,470	9,000	11,390	13,690	15,990	18,290	20,040	21,340	22,640	23,900	25,200
\$450,000 and over	3,140	6,840	9,570	12,160	14,660	17,160	19,660	21,610	23,110	24,610	26,050	27,350

Employee's Withholding Allowance Certificate

2021 Substitute Form W-4

Employer identification number: 53-6002523 F

U. S. House of Representatives

Office of Payroll & Benefits

B215 Longworth HOB

Washington, DC 20515

NAME

Last

First

Middle

If your last name differs from that on your social security card, call 1-800-772-1213.

ADDRESS 1

ADDRESS 2

CITY STATE ZIP

SOCIAL SECURITY NUMBER

EMPLOYEE NUMBER

FEDERAL TAX WITHHOLDING

Filing Status

☐Single or Married
filing separately☐Married filing jointly
(or Qualifying widow(er))☐Head of household (Check only if you're unmarried and pay more than half
the costs of keeping up a home for yourself and a qualifying individual.)

Step 2: (c) If there are only two jobs total, you may check this box. This option is accurate for jobs with similar pay.

☐Step 3: Total Amount you are entering for **Dependent** (annual)

\$

Step 4: (a): Total Amount you are entering for **Other Income** (annual)

\$

Step 4: (b): Total Amount you are entering for **Deductions** (annual)

\$

Step 4: (c): Total Amount you are entering for **Extra Withholding** (per monthly pay period)

\$

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

SIGNATURE

X

Date

STATE TAX WITHHOLDING

I authorize the following action regarding State Income Tax Withholding:

(1)

☐

Begin Withholding

(2)

☐

Change Existing Deduction

(3)

☐

Stop Withholding

Complete the following information only if Box 1 or 2 is checked above.

County

(Maryland residents only):

Marital Status:

Single

Married

If you are a resident of Connecticut, Georgia or Mississippi and claimed Married, select
withholding option to the right that you wish to claim. > > > > >**Note:** If you are a resident of Colorado, New Mexico, North Dakota, and Utah claiming State Tax
withholding, the calculation relies on the 2020 Federal Form W-4 for calculating the amount to withhold.☐

03 - Married Filing Separate

☐

04 - Married Both Spouses Working

☐

05 - Married One Spouse Working

☐

06 - Head of Household

Total number of allowances you are claiming

Additional amount, if any, you want deducted from each paycheck

\$

SIGNATURE

X

Date

STATE TAX WITHHOLDING REGULATIONS.

1. All election authorizations, revocations, or changes for withholding State tax from salaries must be made on the prescribed form issued by the U.S. House of Representatives, CAO Office of Payroll and Benefits.
2. An employee may have only one request for State withholding in effect at any one time.
3. An employee may not have more than two such requests with respect to different states during any one calendar year.
4. Election for withholding is **optional** and an employee may revoke such election.
5. Election, change, or revocation of State tax withholding is effective on the first day of the month in which the request is processed by the CAO Office of Payroll and Benefits, but in no event later than the first day of the first month beginning after the day on which such election, change, or revocation is received by the Office of Payroll and Benefits, with the following exception: when an employee first receives an appointment, his/her request shall be effective on the day of the appointment if the request is made at that time.

STATE ABBREVIATIONS (For use in completing State Tax Withholding) TWO-LETTER STATE ABBREVIATIONS

Alabama	AL	Louisiana.....	LA	Oklahoma.....	OK
Alaska.....	AK	Maine.....	ME	Oregon.....	OR
Arizona.....	AZ	Maryland.....	MD	Pennsylvania.....	PA
Arkansas.....	AR	Massachusetts.....	MA	Puerto Rico.....	PR
California	CA	Michigan.....	MI	Rhode Island.....	RI
Colorado	CO	Minnesota.....	MN	South Carolina.....	SC
Connecticut.....	CT	Mississippi.....	MS	South Dakota.....	SD
Delaware.....	DE	Missouri.....	MO	Tennessee.....	TN
District of Columbia.....	DC	Montana.....	MT	Texas.....	TX
Florida	FL	Nebraska.....	NE	Utah.....	UT
Georgia.....	GA	Nevada.....	NV	Vermont.....	VT
Hawaii	HI	New Hampshire.....	NH	Virginia.....	VA
Idaho	ID	New Jersey.....	NJ	Washington.....	WA
Illinois.....	IL	New Mexico.....	NM	West Virginia.....	WV
Indiana.....	IN	New York.....	NY	Wisconsin.....	WI
Iowa	IA	North Carolina.....	NC	Wyoming.....	WY
Kansas.....	KS	North Dakota.....	ND		
Kentucky.....	KY	Ohio.....	OH		

FEDERAL WITHHOLDING

Copies of the Internal Revenue Service *Employee's Personal Allowance Worksheet* for

Form W-4 can be obtained from the

CAO Office of Payroll and Benefits, B215 Longworth HOB, Washington, DC 20515.

Direct Deposit Form

Instructions:

1. This form can be used to identify up to two (2) direct deposit accounts.
2. Complete all sections of this form, print, and return with all required supporting documents to the Office of Payroll and Benefits.
3. This form(s) **will not** be processed if submitted with incomplete information.
4. This form(s) **will not** be processed if submitted without an accompanying voided check **or** an ACH routing document **provided by your financial institution**.
5. This office reserves the right to pull back any funds sent to your financial institution in error.
6. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Direct Deposit Form

Date: _____

First Name: _____

Last Name: _____

Employee Social Security Number: _____

Address: _____

City, State Zip: _____, _____

Email: _____

Daytime Telephone: _____ Evening Telephone: _____

Return the completed form(s) and accompanying documents to:

**Office of Payroll and Benefits B-
215 Longworth House Office Building
Washington, D.C. 20515
(202) 225-1435 phone
(202) 225-5969 fax**

On this page you may only select a Primary or a Secondary account.

New Change

Primary Direct Deposit Account

The account you want the balance of your salary to go to.

If you don't have a Secondary Direct Deposit Account, all funds will go to this account.

New Change Cancel

Secondary Direct Deposit Account (choose % or \$ and enter value below)

A portion of your salary goes to this account.

You must designate either a % (less than 100%) or a dollar value you want sent to this account.

(If secondary Direct Deposit) Enter value for _____ % (less than 100%) OR \$ _____

Is this a Checking or Savings account?

Financial Institution Name field requires value for page to print

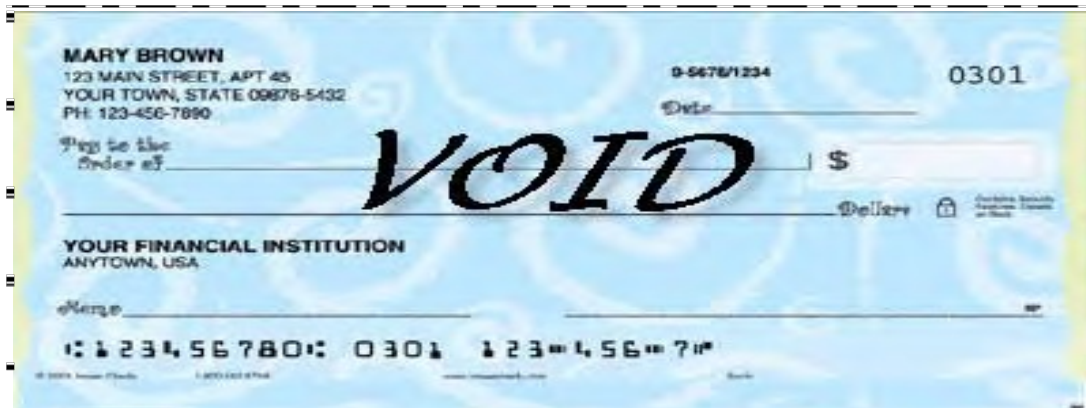
Financial Institution Name: _____

Financial Institution Address: _____

Financial Institution City, State Zip: _____

Financial Institution Phone Number: _____

Affix voided check here (use tape please) – or append ACH routing form from your banking institution



PLEASE READ THE FOLLOWING INFORMATION BEFORE SUBMITTING:

1. These forms ***will not*** be processed without an accompanying voided check ***or*** an ACH routing document ***provided by your financial institution.***
2. This office reserves the right to pull back any funds sent to your financial institution in error.
3. All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Signature: _____

Direct Deposit Form

Date: _____

First Name: _____

Last Name: _____

Employee Social Security Number : _____

If you would you like to add another (secondary) Direct Deposit Account please fill in the information below, otherwise, print and sign the forms then submit the forms as noted.

Return the completed form(s) and accompanying documents to:

Office of Payroll and Benefits B-215 Longworth House Office Building
Washington, D.C. 20515
(202) 225-1435 phone
(202) 225-5969 fax

New Change Cancel

Secondary Direct Deposit Account

(Enter either a % or an amount)

A portion of your salary goes to this account.

You must designate either a % (less than 100%) or a dollar value you want sent to this account

Enter value for _____ % (less than 100%) OR \$ _____

Is this a Checking or Savings account?

Financial Institution Name field requires value for page to print

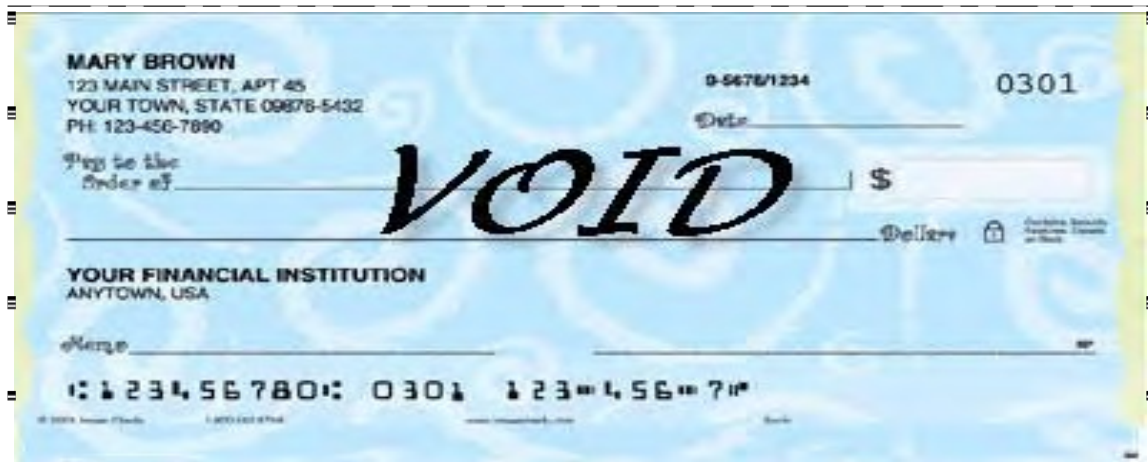
Financial Institution Name: _____

Financial Institution Address: _____

Financial Institution City, State Zip: _____

Financial Institution Phone Number: _____

Affix voided check here (use tape please) – or append ACH routing form from your banking institution



PLEASE READ THE FOLLOWING INFORMATION BEFORE SUBMITTING:

- These forms **will not** be processed without an accompanying voided check **or** an ACH routing document **provided by your financial institution**.
- This office reserves the right to pull back any funds sent to your financial institution in error.
- All ***Expense Reimbursements*** will be paid to your Primary Direct Deposit Account, unless you provide alternative banking information to the CAO Office of Financial Solutions, Accounting, at 202-226-2277.

Signature: _____



THRIFT SAVINGS PLAN ELECTION FORM

TSP-1

Use this form to start, stop, or change the amount of your contributions to the Thrift Savings Plan (TSP).

Before completing this form, please read the *Summary of the Thrift Savings Plan* and the instructions on the back of this form. Type or print all information. **Return the completed form to your agency personnel or benefits office.** Your agency should return a copy to you after completing Section V.

Note: To choose your investment funds, see the instructions in the General Information section on the back of this form.

I. INFORMATION ABOUT YOU

1. _____
Name (Last) (First) (Middle)
2. _____
Street Address City State Zip Code
3. _____ - _____ - _____
Social Security Number
4. (_____) _____ - _____
Daytime Phone (Area Code and Number)
5. US HOUSE OF REPRESENTATIVES
Office Identification (Agency and Organization)

II. CHOOSE THE AMOUNT OF YOUR CONTRIBUTIONS

Your choice will cancel
all previous elections.

To start or change the amount of traditional (pre-tax) or Roth (after-tax) contributions to your TSP account, enter **either** a whole percentage of your basic pay per pay period **or** a whole dollar amount per pay period for each type of contribution you elect. (You may choose a percentage for one type of contribution and a dollar amount for the other type of contribution.) **Remember:** A blank line next to a type of contribution equals 0% or \$0 contributed.

6. Traditional (Pre-Tax) Contributions _____ .0% **OR** 7. \$ _____ .00
8. Roth (After-Tax) Contributions _____ .0% **OR** 9. \$ _____ .00

III. STOP SOME OR ALL OF YOUR CONTRIBUTIONS

To stop all or just one type of your contributions to the TSP, check the box in Item 10 that applies and complete Section IV. Your payroll contributions will stop no later than the first full pay period after your agency employing office receives this form. (If you are a Federal Employees Retirement System [FERS] employee and you stop your contributions, your Agency Matching Contributions will stop, but Agency Automatic [1%] Contributions will continue. Read the instructions on the back.)

10. ☐ I choose not to save for my retirement. Please stop all my payroll contributions to my TSP account.
- ☐ Stop only my traditional (pre-tax) payroll contributions to my TSP account.
- ☐ Stop only my Roth (after-tax) payroll contributions to my TSP account.

If you are a newly hired (or rehired) employee, you can generally stop your automatic employee contributions before they start if you submit this form to your agency before the end of your first full pay period. (See note on back.)

IV. SIGNATURE

11. _____
Participant's Signature
12. _____
Date Signed (mm/dd/yyyy)

V. FOR EMPLOYING OFFICE USE ONLY

13. 0004832
Payroll Office Number
14. _____
Receipt Date (mm/dd/yyyy)
15. _____
Effective Date (mm/dd/yyyy)
16. _____
Signature of Agency Official

PRIVACY ACT NOTICE. We are authorized to request the information you provide on this form under 5 U.S.C. chapter 84, Federal Employees' Retirement System. Your agency or service will use this information to identify your TSP account and to start, change, or stop your TSP contributions. In addition, this information may be shared with other federal agencies for statistical, auditing, or archiving purposes. The information may also be shared with law enforcement agencies investigating a violation of civil or criminal law, or agencies implementing a statute, rule, or order.

It may be shared with congressional offices, private sector audit firms, spouses, former spouses, and beneficiaries, and their attorneys. Relevant portions of the information may also be disclosed to appropriate parties engaged in litigation and for other routine uses as specified in the Federal Register. You are not required by law to provide this information, but if you do not provide it, your agency or service will not be able to process your request.

ORIGINAL TO PERSONNEL FOLDER
Provide a copy to the employee and to the payroll office.

Page 19

Form TSP-1 (10/2020)
PREVIOUS EDITIONS OBSOLETE

TSP-1, INFORMATION AND INSTRUCTIONS

GENERAL INFORMATION

You may start, stop, or change your contributions at any time. Your TSP election will stay in effect until you submit another election or until you leave federal service.

Important note for new TSP participants: All contributions to your account will be invested in the Lifecycle (L) Fund most appropriate for your age unless you direct us to allocate your contributions differently. The TSP publication *Summary of the Thrift Savings Plan* describes all of your investment choices and discusses their risks and advantages. For more information, you can also obtain a copy of the TSP Fund Information sheets. (The most current versions of TSP forms and publications are available on the TSP website at tsp.gov.)

To choose your investment fund(s), log into your account at tsp.gov or call the ThriftLine at 1-877-968-3778. Outside the U.S. and Canada, call 404-233-4400. On the TSP website, you will need your TSP account number and web password. If you use the ThriftLine, you will need your TSP account number and ThriftLine Personal Identification Number (PIN). If you are a new participant, your TSP account number, ThriftLine PIN, and web password will be mailed to you (separately) after your account has been established.

If you change your address, notify your **agency** immediately to correct your records for your TSP account.

SECTION I

Complete all items in this section.

SECTION II

Your choice will cancel all previous elections.

Example

Previous Election:

Traditional	5%
Roth	2%

New Election:

Traditional	5%
Roth	10%

Complete this section to start your TSP contributions or to change the amount and type of contributions. Because whatever you enter in this section will cancel all previous elections, be sure to indicate exactly what percentages/amounts you want to contribute, even if part of your election has not changed (see the example in the margin). You can elect to make traditional (pre-tax) and Roth (after-tax) contributions simultaneously. **Traditional contributions** come out of your pay **before** income taxes are calculated; you pay income taxes on these contributions and their earnings when you withdraw them. **Roth contributions** are made from your pay **after** taxes, and the earnings grow in your account tax-deferred. Withdrawals of Roth contributions are tax-free. The earnings associated with Roth contributions are also tax-free, but only if 5 years have passed since January 1 of the calendar year in which you made your first Roth contribution, **and** you have reached age 59½, have a permanent disability, or have died. **Note for FERS:** All agency contributions to your account are tax-deferred, even if they are matching your Roth contributions.

Complete **either** Item 6 **or** Item 7 (not both) for traditional (pre-tax) contributions; **either** Item 8 **or** Item 9 (not both) for Roth contributions. You may choose a percentage of basic pay for one type of contribution and a dollar amount (as little as \$1) for the other type of contribution.

If you choose a percentage of basic pay, your contribution amount will automatically increase when you receive a pay raise.

If you choose a dollar amount per pay period, your contribution amount will not increase when you receive a pay raise; you must submit a new Form TSP-1 to change the amount.

Contribution limit. The **total** of your traditional and Roth contributions cannot exceed the Internal Revenue Code (IRC) annual elective deferral limit, which may change each year. For the current limit, visit "Contribution Limits" at tsp.gov.

SECTION III

Complete Item 10 to stop all or just one type of your contributions. You may restart your contributions at any time.

FERS employees: Your Agency Automatic (1%) Contributions will continue after you stop your employee contributions, but you will no longer receive valuable Agency Matching Contributions. (If you restart your contributions, the matching contributions will resume.)

Note for newly hired or rehired FERS or CSRS employees: Your agency automatically deducts 5% of your pay, tax-deferred, and deposits the money in your TSP account for your retirement savings. If you want all or any portion of your automatic contributions to be after-tax Roth contributions, **you must complete Section II** and indicate what percentages or amounts you want as traditional (pre-tax) and Roth (after-tax) contributions. You can stop your automatic employee contributions before they start if you submit this form to your agency at the start of your first full pay period, subject to your agency's processing deadlines. If your agency has already begun to deduct your automatic employee contributions from your pay each pay period, you are entitled to request a refund of your initial contributions by submitting Form TSP-25, *Automatic Enrollment Refund Request*. We must receive Form TSP-25 within 90 days of your first contribution.

SECTION IV

You must complete this section.

SECTION V

(To be completed by personnel or benefits office)

The Receipt Date (Item 14) is the date that a **properly completed** form is received by the agency personnel office. If the form has not been properly completed, it should be returned to the employee.

Requests must be processed immediately for new and rehired employees who want to stop automatic enrollment before it begins. This will help avoid a payroll deduction that may have to be refunded. The Effective Date (Item 15) must be no later than the first full pay period after receipt of a properly completed form.

You should provide the participant with a copy of this completed election form.

**U.S. House of Representatives
Washington DC 20515**

**Certificate of Relationship/Nonrelationship to
Any Current Member of Congress**

Date_____

To:_____

(Employing Authority)

I certify that I do not have any of the following relationships to any current Member of Congress.

father	nephew	sister-in-law
mother	niece	stepfather
son	husband	stepmother
daughter	wife	stepson
brother	father-in-law	stepdaughter
sister	mother-in-law	stepbrother
uncle	son-in-law	stepsister
aunt	daughter-in-law	half-brother
first cousin	brother-in-law	half-sister

I certify that I am the_____of the

(Relationship)

Honorable_____

(Name of Member to whom related)

(Employee)



U.S. House of Representatives Principles of Behavior for Information System Users

GUIDELINES FOR USE OF INFORMATION SYSTEMS

The following principles apply to House employees and contractors using or providing support for House information systems. Additional guidance unique to specialized systems may be provided as needed. These principles are based on Federal law, the House Code of Official Conduct, Committee on House Administration (CHA) Regulations, and House Information Security Policies (HISPOLs). At the discretion of the Employing Authority, there may be consequences for non-compliance.

USERS ARE RESPONSIBLE FOR ALL ACTIONS PERFORMED WITH THEIR PERSONAL USER ID.

- Users shall make every effort to protect information security through effective use of user IDs and passwords.
- User IDs and passwords are for individual use only.
- Users must not disclose their passwords to anyone. Users must take necessary steps to prevent anyone from gaining knowledge of their passwords.

REGULATIONS, POLICIES, AND PROCEDURES MUST BE FOLLOWED.

- House information systems may not be used contrary to public law, House Rules, CHA regulations, and HISPOLs.
- All computer resources assigned, controlled, assessed, and maintained by House employees and contractors are subject to periodic test, review, and audit.

ACCESS TO INFORMATION MUST BE CONTROLLED.

- Users must access and use only information for which they have official authorization.
- Users must protect information from unauthorized disclosure or modification.
- Users must protect information so that it is available on a timely basis to meet House operational requirements.

USERS ARE RESPONSIBLE FOR THE PROPER USE OF COMPUTER RESOURCES.

- Users are accountable for their own actions and responsibilities related to information and information systems entrusted to them.
- Users must protect computer equipment from damage, abuse, theft, sabotage, and unauthorized use.
- Users must use approved software in a safe manner so that it is protected from damage, abuse, theft, sabotage, and unauthorized replication or use (copyright infringement).
- Users must participate in annual security awareness training to ensure their knowledge of current policies and procedures.
- Users must report suspected security violations, incidents, and vulnerabilities to the Information Systems Security Office.

USER CERTIFICATION

I certify that I have read the above statements, fully understand my responsibilities, and agree to comply. I recognize that any violation of the requirements indicated above may be cause for disciplinary actions.

Name (please print): _____

Signature: _____

Date: _____

The following page is an optional form that does NOT have to be completed on the date of hire. If you wish to apply for this benefit you MUST submit the form by the below noted deadline.

<u>Program</u>	<u>Form</u>	<u>Time Limit for Application</u>
Life Insurance	SF-2817	Staff are automatically enrolled in Basic Life Insurance unless they submit a waiver of life insurance coverage. Staff have 60 days, from the date of their appointment, to elect optional Life Insurance coverage.

Other Benefits

Health Insurance (FEHB) - SF-2809 Staff eligible for the FEHB Program must enroll within 60 days of their appointment date of hire or enroll on-line at EBIS, <https://platform.grbinc.com/Account/Login?License=1089>.

Health Insurance (DC SHOP) - Online Only Staff designated to participate in the Public exchanges for health insurance must enroll within 30 days of their appointment date of hire on-line at <https://www.dchealthlink.com/>

Supplemental Dental and Vision Insurance - Enrollment is conducted on-line at <https://www.benefeds.com> within 60 days of your appointment.

Flexible Spending Account - Enrollment is conducted on-line at www.FSAFEDS.com within 60days of your appointment.

Life Insurance Election
Federal Employees' Group Life Insurance Program
See Privacy Act Statement on back of Part 3

1 General Instructions
By law, unless you waive all coverage or are ineligible, you are automatically covered for Basic life insurance as an employee. When you first become eligible for FEGLI, you may (1) do nothing and have Basic automatically, (2) elect Basic and any or all of the options, or (3) waive all life insurance coverage. If you are changing a previous election, see the back of Part 3 - Employee Copy.

- Read the back of Part 3 - Employee Copy carefully.
- Assignees completing this form should read Items 5 and 6 on the back of Part 3.
- Give all parts of your completed form to your employing office. Your employing office will complete Section 6 of this form (or its electronic equivalent) and return your copy to you.

This election supersedes all previous elections.

2 Fill in identifying information concerning the employee.

Name (last, first, middle)		Date of birth (mm/dd/yyyy)	Social Security Number
Employing department or agency	OWCP claim number, if applicable	Location of department or agency where you work (city, state, ZIP code)	Daytime telephone number (including area code)
US HOUSE OF REPRESENTATIVES		B215 LONGWORTH HOB WASHINGTON DC 20515	

3 To elect or retain Basic, sign and date below. If you do not sign for Basic, you (or your assignee) may not elect or retain any form of optional insurance. If you do not want any insurance at all, skip to Section 5.

Basic	I want Basic. I authorize deductions to pay my share of the cost. (Basic may be provided without cost to U.S. Postal Service employees.)	
	SIGNATURE (Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are not valid.)	Date (mm/dd/yyyy)

4 Optional If you signed for Basic in item 3 above, you may elect or retain any or all of the following options (UNLESS you have previously waived any or all of these options, in which case you may elect only those options which you are eligible to elect as outlined in the FEGLI Program Booklet). Sign the box(es) below for any option(s) you are eligible for and wish to elect or retain. If you do not sign for an option, you have waived it and your future opportunities to enroll in it are strictly limited.

You will not be covered for any option(s) for which you do not sign below, regardless of whether you previously elected the option(s).

Option A - Standard	Option B - Additional	Option C - Family
I want Option A. I authorize deductions to pay the full cost.	I want Option B in the multiple of my annual basic pay I indicate below. I authorize deductions to pay the full cost.	I want Option C in the multiple I indicate below. I understand that each multiple is worth \$5,000 upon the death of my spouse, and \$2,500 upon the death of an eligible child. I authorize deductions to pay the full cost.
<input type="checkbox"/> 1 times my pay	<input type="checkbox"/> 3 times my pay	<input type="checkbox"/> 3 multiples
<input type="checkbox"/> 2 times my pay	<input type="checkbox"/> 4 times my pay	<input type="checkbox"/> 4 multiples
	<input type="checkbox"/> 5 times my pay	<input type="checkbox"/> 5 multiples
SIGNATURE (Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are not valid.)	SIGNATURE (Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are not valid.)	SIGNATURE (Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are not valid.)
Date (mm/dd/yyyy)	Date (mm/dd/yyyy)	Date (mm/dd/yyyy)

5 If you want NO life insurance coverage, sign and date below.

Waiver of all life insurance coverage	I want NO life insurance coverage. I understand that any life insurance I have will stop at the end of the last day of the pay period in which my employing office receives this waiver. Further, I cannot get Basic life insurance unless (1) I wait at least 1 year after I sign this form and submit satisfactory medical information, or (2) I experience a life event, or (3) I have a break in Federal service of at least 180 days, or (4) I participate in an open season, which is held infrequently. I understand that I cannot get any optional insurance unless I first have Basic. I understand that my decision to waive life insurance coverage now may affect my eligibility for coverage as a retiree.	
	SIGNATURE (Do not print. Only you or your assignee may sign. Signatures by guardians, conservators or through a power of attorney are not valid.)	Date (mm/dd/yyyy)

6 Agency Remarks:

Name and address of employing office	Date received in employing office (mm/dd/yyyy)	Effective date of coverage (mm/dd/yyyy)	If new/newly eligible employee, enter "0" for event. Number of event permitting change (See back of Part 2)
U.S. HOUSE OF REPRESENTATIVES CAO OFFICE OF PAYROLL AND BENEFITS B215 LONGWORTH HOUSE OFFICE BUILDING WASHINGTON DC 20515-6604	I followed the instructions on the back of Part 1. Signature of authorized agency official		

The employee's copy of this form, when completed by the employing office, together with the FEGLI Program Booklet (FE 76-21 or FE 76-20 for U.S. Postal Service employees) constitute the employee's Certificate (proof) of Insurance.

Instructions for Agencies

1. Who Should File This Form?

- ❖ New employees eligible for life insurance who want optional insurance or no insurance. **Note:** New employees who want only Basic do not have to file.
- ❖ Employees appointed to positions that allow life insurance coverage following service in positions that did not allow life insurance coverage.
- ❖ Employees who want to change their life insurance.
- ❖ Reinstated employees who filed a previous waiver of any type of life insurance, were separated from service for at least 180 days, and wish to elect coverage.
- ❖ Assignees who want to decrease or cancel coverage.
- ❖ Department of Defense employees designated "emergency essential" and civilian employees deployed in support of a contingency operation per Public Law 110-417.

Give a new employee a copy of the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) when he or she reports for duty and ask the employee to return the completed SF 2817 as soon as possible (preferably before the end of the first pay period), but no later than 60 days after his or her appointment.

Employees with prior government service in non-excluded positions who were separated after March 31, 1981, should have an SF 2817 on file in their personnel folders, and that election or waiver of coverage may still be in effect. **Do not accept a new SF 2817 unless the employee has a break in Federal service of at least 180 days or is eligible to cancel a previous waiver that has been in effect for at least one year, or wishes to reduce coverage.**

Until you verify an employee's SF 2817 on file, make deductions based on his or her statement about earlier insurance coverage. Once coverage is confirmed, make any necessary adjustments to correct the withholdings.

An employee may at any time file an SF 2817 to waive or reduce coverage, **unless** the employee has assigned his/her insurance coverage. If the employee has assigned the insurance, **only** the assignee(s) may waive or reduce the coverage (except for Option C which cannot be assigned).

2. How Else Can An Employee Elect More Coverage?

- ❖ **Provide Medical Information.** An employee may elect or increase Basic, Option A, or Option B insurance (but **not** Option C), if a previously completed SF 2817 waiving coverage has been in effect for more than one year, by submitting satisfactory evidence of insurability via a *Request for Insurance*, SF 2822. If approved, the employee should make the election on the SF 2817 and submit to the employing agency. More details are contained on the SF 2822.
- ❖ **Experience A Qualifying Life Event.** An employee may elect Basic, Option A, Option B and/or Option C within 60 days following a FEGLI qualifying life event. These events are: marriage, divorce, spouse's death, or the acquisition of an eligible child.

For Option B and Option C, an employee may elect from 1 to 5 multiples (up to 5 total) based on the life event.

- ❖ An employee who is already enrolled in Option B and/or Option C may elect from 1 to 5 multiples (up to 5 total) within 60 days based on the life event.

3. What Should You Review After The Employee Submits This Form?

Review all three parts of the SF 2817 to see that they are legible and complete. If an employee signs the box for Option A, Option B, or Option C, he or she must also sign Section 3, Basic. If the employee uses a downloaded copy, be sure all parts are completed. Contact the employee if any part is unclear.

Only the employee may sign this form in Sections 3, 4, or 5, with one exception (noted below). Signatures by guardians, conservators, or through a power of attorney are **NOT** valid.

Exception: If the employee assigned the insurance, only the assignee(s) may **waive** or reduce some or all of the employee's coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to the employee). Please note that assignees cannot increase the employee's coverage. Only the employee can do that.

The employee is solely responsible for ensuring that the SF 2817 accurately reflects his or her intentions.

If the employee is electing new coverage, always make sure that the authorized agency official confirms that the employee is eligible for the coverage, and that the official signs the form in Section 6.

4. When Did You Receive This?

Enter the date the employing office received this form.

5. What Is The Event Permitting The Change?

Enter the number of the event permitting a change, if applicable. See the Table of Effective Dates on the back of Part 2 for event numbers.

6. What Is The Effective Date Of The Coverage?

Enter the effective date of coverage. For new and newly eligible employees: Basic is effective on the first day the employee is in a pay and duty status; Optional coverage is effective on the first day the employee is in a pay and duty status on or after the day the employing office receives the SF 2817. For changes in elections, see the Table of Effective Dates on the back of Part 2. If there is more than one effective date for this election, the 2nd effective date should be noted in Part 6 under "Remarks."

7. What Do You Do With Parts 1, 2, and 3?

After completion, give Part 3 to the employee. File Part 1 in the employee's personnel folder. Destroy Part 2 after payroll office use. Part 3, and the *FEGLI Program Booklet* (FE 76-21, or FE 76-20 for U.S. Postal Service employees), serve as the employee's certificate of insurance.

8. Where Can You Find More Information?

Consult the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) or the FEGLI Handbook, which are available on the FEGLI web site at www.opm.gov/insure/life.

Table of Effective Dates: Changes in Life Insurance Coverage Deductions: Begin, increase, stop or decrease in the same pay period in which coverage begins, increases, stops, or decreases.				
Event Allowing Change	Change Permitted? <i>(To elect any option, employee must elect or retain Basic)</i>			
	Basic	Option A - Standard	Option B - Additional	Option C - Family
0. New/Newly Eligible Employee:	Yes. See "Instructions to Agencies", #5, back of Part 1.	Yes. Same as Basic.	Yes. Same as Basic.	Yes. Same as Basic.
1. PROVIDING MEDICAL INFORMATION: Approval of Request for Insurance (SF 2822) by the Office of Federal Employees' Group Life Insurance (OFEGLI).	Yes. Coverage is automatically effective the first day the employee is in a pay and duty status on or after date of OFEGLI's approval. Time Limit - on or after OFEGLI's date of approval. If employee is not in a pay and duty status within 60 days, Basic does NOT become effective, and the employee must start over.	Yes. Coverage is effective the first day the employee is in a pay and duty status on or after the date of OFEGLI's approval and the agency receives the SF 2817. Time Limit - Employee must submit the SF 2817 and be in a pay and duty status within 60 days after date of OFEGLI's approval. If employee is not in a pay and duty status or doesn't submit the SF 2817 within those 60 days, Option A does not become effective, and the employee must start over.	Yes. Same as Option A.	No. An employee may NOT elect Option C by providing medical information.
2. LIFE EVENT: Marriage, divorce, death of spouse, or acquisition of an eligible child.	Yes. Coverage is effective the day of the event if the SF 2817 is received before the event and the employee is in pay and duty status on the day of the event . Otherwise, Coverage is effective the first day in pay and duty status after the event and after receipt of the SF 2817. Time Limit - Agency must receive the SF 2817 and proof of the event within 60 days after the day of the event.	Yes. Same as Basic. Coverage - Same as Basic. Time Limit - Same as Basic.	Yes. Same as Basic. Employee may elect or increase multiples (up to 5 total). Coverage - Same as Basic. Time Limit - Same as Basic.	Yes. Employee may elect or increase multiples (up to 5 total). If the employee has Basic, Coverage is effective the day the employing office receives the election, or the date of the event, whichever is later. If Basic and Option C are elected at the same time, Option C is effective when Basic becomes effective. Time Limit - Same as Basic. (Note: If the employee already has Basic, there is no pay and duty status requirement for Option C.)
3. REINSTATEMENT: Employee is reinstated after a break in service of at least 180 days in a position that is not excluded from life insurance by law or regulation.	Yes. Coverage is effective on the first day the employee is in a pay and duty status, unless waived by employee.	Yes. Employee may elect Option A within 60 days after reinstatement. However, if employee does not submit SF 2817 electing coverage within 60 days after reinstatement, s/he has the same Optional insurance carried before the break in service effective the beginning of the reinstatement.	Same as Option A.	Same as Option A.
4. REINSTATEMENT: Employee is reinstated after a break in service of at least 180 days in a position that is excluded from life insurance by law or regulation.	No. However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is in a pay and duty status on or after being converted to such a position.	No. However, if employee is later converted to a non-excluded position, the coverage is effective on the first day the employee is in a pay and duty status in the converted position on or after the date the agency receives the SF 2817 electing such coverage. Time Limit - Employee must submit the SF 2817 within 60 days after conversion to an eligible position.	Same as Option A.	Same as Option A.
5A. CANCELING/ WAIVING COVERAGE: employee/assignee or 5B. REDUCING OPTION B and/or OPTION C MULTIPLES: employee/assignee	A. Yes. If the coverage is canceled in the first pay period, no premiums are due. Otherwise, coverage stops at the end of the last day of the pay period in which the agency receives the SF 2817, with no 31-day extension of coverage. Time Limit - None. Employee may cancel coverage at any time. However, if the insurance is assigned, only the assignee(s) may cancel B. Not applicable.	A. Same as Basic. B. Not applicable.	A. Same as Basic. B. Yes. Employee may at any time reduce the number of multiples, unless the insurance has been assigned. In that case, only the assignee(s) may reduce coverage – the employee may not. This new coverage is effective at the beginning of the pay period following the one in which the employing office receives the SF 2817.	A. Same as Basic. Option C cannot be assigned. If Option C is canceled because there no longer are eligible family members, the effective date is retroactive to the end of the pay period in which there no longer are any eligible family members. The employing agency must refund Option C premiums retroactive to that effective date. B. Yes. Employee may at any time reduce the number of multiples. This new coverage is effective at the beginning of the pay period following the one in which the employing office receives the SF 2817. Assignee(s) cannot reduce Option C.
6. Open Season.	If permitted under conditions specified by OPM.	Same as Basic.	Same as Basic.	Same as Basic.
7. CERTAIN DEPT. OF DEFENSE AND CIVILIAN EMPLOYEES AFFECTED BY PUBLIC LAWS 106-398 AND 110-417:	Yes , if employing agency determines employee meets criteria to elect coverage. Coverage is effective the first day the employee is in a pay and duty status on or after the date the agency receives the SF 2817. Time Limit - Agency must receive the SF 2817 within 60 days of the date the employee receives official notice of deployment in support of a contingency operation or designation as an emergency essential employee.	Same as Basic.	Same as Basic. Employee may elect or increase multiples (up to 5 total).	No. An employee may NOT elect Option C via these provisions of law.

Instructions for Employees

1. General Information

The major provisions of this program are described in the *Federal Employees' Group Life Insurance (FEGLI) Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees). Please read the entire booklet carefully. Your completed copy of this election form (SF 2817) and the FEGLI Program Booklet constitute your certificate (proof) of insurance. These publications, as well as comprehensive FEGLI information, are available at www.opm.gov/insure/life.

2. I Am A New Employee or Newly Eligible for Life Insurance. What Do I Need To Know?

You are automatically enrolled in Basic (even if you don't complete this form) unless you waive it. If you waive Basic, you automatically waive all forms of Optional insurance. You will not have any Optional insurance unless you elect it.

To elect Basic: You do not have to submit this form unless you also wish to elect Optional insurance.

To waive Basic: Sign Section 5 of the form and give it to your employing office. Your agency will withhold Basic premiums from your salary from your first day at work in a pay status UNLESS you submit your waiver before the end of your first pay period.

To elect Optional: Sign Section 3 and one or more of the blocks in Section 4 of the form and give it to your employing office within 60 days after the date you are appointed or first become eligible for life insurance.

To waive Optional: If you do not sign for a particular type of Optional coverage in Section 4, *you automatically waive that coverage*.

3. I Am An Employee With Prior Government Service. What Do I Need To Know?

When you return to work after a break in service of *less than 180 days*, your human resources office will automatically enroll you in the same coverage that you had before you left your prior position, if any. This coverage will be effective on your first day in a pay and duty status in a FEGLI eligible position. You will have to qualify to elect other coverage (open season, providing medical information, or a life event). If you waived some coverage, then the waiver of that coverage is still in effect.

When you return to work after a break in service of *180 days or more*, your human resources office will automatically enroll you in Basic and the same Optional insurance that you had in your prior position. This coverage will be effective on your first day in a pay and duty status in a FEGLI eligible position. You may elect more insurance (if you don't already have the maximum) within 60 days of your appointment to an eligible position. If you previously waived coverage then that waiver is no longer in effect. You will automatically be enrolled in Basic, unless you file a new waiver.

See the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service Employees) for more details.

4. I Am A Reemployed Annuitant. What Do I Need To Know?

If you waive your insurance when you return to Federal Service as a reemployed annuitant, you also waive your insurance with your retirement annuity. You will have no FEGLI life insurance. It is important that you contact your human resources office and inform them that you are a reemployed annuitant. More details can be found in OPM Form 1482, *Agency Certification of Status of Reemployed Annuitants*.

5. What If I Assigned My Coverage?

If you have assigned your insurance by filing an RI 76-10, *Assignment of Federal Employees' Group Life Insurance*, you may not cancel any of your insurance coverage (except Option C). Only the assignee(s) may cancel your coverage. However, you may elect new coverage if you otherwise meet the requirements for electing such coverage. Any new coverage you elect will automatically be subject to your existing assignment, except for Option C, which you cannot assign. All assignments are automatically canceled after a break in service of at least 31 days, or upon cancellation of all life insurance coverage by the assignee(s).

6. I Am An Assignee. What Can I Do?

If you are completing this form in order to cancel some or all of the employee's life insurance coverage, you must sign the form. The information in Section 2 of the form refers to the employee, but you must sign in Section 3, 4 or 5, as applicable. Indicate "assignee" after your

signature. Return the completed form to the employee's employing office. If the insured is an annuitant, return the completed form to OPM, Retirement Operations Center, P.O. Box 45, Boyers, PA 16017-0045. See #11 for where to return the completed form if the insured is a compensationner.

7. How Do I Complete The Form?

Follow the instructions for each item carefully. After you fill out the form, review it to be sure it is complete and correct. The following checklist should help.

If you sign Section 3, you elect (or retain) **Basic**.

If you sign any block in Section 4, you elect (or retain) **Optional Insurance**. You must also elect (or retain) Basic by signing Section 3.

If you sign Section 4 for Option B and/or Option C, you must also mark one of the five boxes to show how many multiples you wish to elect (or retain). Do not mark more than one box.

Be Sure You Sign For All Options You Want. This election supersedes all previous ones. If you have optional coverage and wish to keep it, you must sign the appropriate box(es). If you do not sign for it, you have waived it.

If you sign Section 5, you waive all FEGLI coverage.

Only you, the employee, may sign this form. Signatures by guardians, conservators, or through a power of attorney are not acceptable.

Exception: If you have assigned your insurance, only the assignee(s) may cancel some or all of your coverage. In that case, the assignee(s) must sign the form (although the information in Section 2 must refer to you).

REMEMBER THAT YOU, NOT YOUR AGENCY, ARE RESPONSIBLE FOR ENSURING THAT YOUR SF 2817 (OR ITS ELECTRONIC EQUIVALENT) IS CORRECT AND ACCURATELY REFLECTS YOUR INTENTIONS. IF YOU DO NOT SIGN FOR IT, YOU HAVE CANCELED/WAIVED IT.

8. Open Seasons

If you elected coverage during an Open Season, and that coverage has not yet become effective, and you want to make a further change to your FEGLI coverage on this SF 2817, you should check with your employing office. That office can tell you about any special election procedures that may apply.

9. What If I Waive or Reduce My Coverage?

If you do not sign for a particular type of coverage, you have waived that coverage. If you waive Basic or one or more of the options, your opportunities to enroll in the coverage you waived are strictly limited. A waiver may also affect your eligibility to continue coverage into retirement. See the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) for more details.

10. Where Do I Send The Completed Form?

After you have completed this form and verified that it accurately reflects your intentions, send the entire form (without separating the parts) to your human resources office. Do *not* send the form to OPM or OFEGLI.

11. What If I Receive Workers' Compensation?

If you are receiving compensation payments from the Office of Workers' Compensation Programs (OWCP), provide your OWCP number in Section 2 of the form. If you are still employed, return the completed form to your employing office. If you are not still employed or if you have been receiving compensation payments for at least 12 months, see your human resources office about your continued eligibility under the FEGLI Program.

12. How Do I Verify That My Agency Processed My Election?

After your employing office processes your election form, you will receive an SF 50, *Notification of Personnel Action*. A two digit code appearing on the SF 50 will explain your insurance coverage. These codes are explained in Part 2 of the SF 2817. Also check your pay statement for the correct withholdings. If you are insured as a compensationner, you will receive a notice from OPM which will explain your insurance coverage.

13. Where Do I Get More Information About The FEGLI Program?

Consult the *FEGLI Program Booklet* (FE 76-21 or FE 76-20 for U.S. Postal Service employees) or the *FEGLI Handbook* (RI 76-26), which are available on the FEGLI web site at www.opm.gov/insure/life.

Privacy Act and Public Burden Statements

Chapter 87, title 5, U.S. Code, Federal Employees' Group Life Insurance, authorizes solicitation of this information. The data you furnish will be used to determine your life insurance coverage. This information may be shared and is subject to verification, via paper, electronic media, or through the use of the computer matching programs, with national, state, local or other charitable or social security administrative agencies to determine and issue benefits under their programs or law enforcement agencies, when they are investigating a violation or potential violation of civil or criminal law. Executive Order 9397 (November 22, 1943) authorizes use of the Social Security Number to distinguish between the applicant and people with similar names. Failure to furnish the requested information may result in your agency's inability to determine your life insurance coverage.

We estimate this form takes an average of 15 minutes to complete including the time for getting the needed data and reviewing both the instructions and completed form. Send comments regarding our estimate or any other aspect of this form, including suggestions for reducing completion time, to the Office of Personnel Management (OPM), Retirement Services Publications Team (3206-0230), Washington, DC 20415-3430. The OMB Number, 3206-0230 is currently valid. OPM may not collect this information, and you are not required to respond, unless this number is displayed.

**U.S. HOUSE OF REPRESENTATIVES
OATH OF OFFICE
PAYROLL AND BENEFITS INFORMATION**

PLEASE USE TYPEWRITER OR PRINT IN INK

A. IDENTIFICATION:

Name: Last-First-Middle

Date of Birth (Month/Day/Year)

Social Security Number

Office Telephone Number (Include Area Code)

Employing Office

Home Telephone Number (Include Area Code)

B. MAILING ADDRESS FOR EARNINGS STATEMENT AND W-2:

IN ORDER TO RECEIVE ANY PAY FOR SERVICES, all new and returning employees, and
employees taking a break in service must complete Parts C through H.

C. OATH OF OFFICE:

I, _____, do solemnly swear (or affirm) that I will support
and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true
faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of
evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter.
So help me God.



Signature (Required for Appointment)

Date

D. BENEFITS DEADLINE ACKNOWLEDGEMENT:

I understand that from the date of my appointment, I must enroll in Health Benefits (SF2809) within 60 days, if eligible
for FEHB. Failure to submit the Health Benefits (SF2809) form within 60 days of the date of appointment will exclude me
from FEHB enrollment, in most cases, until Open Season or a qualifying life event (QLE). If deemed to be covered by
health exchanges created under the Affordable Care Act (ACA), I understand that I have 30 days to register with the
DC Health Insurance Marketplace at www.dchealthlink.com. Thrift Savings Plan (TSP-1) elections are required with
all New employee Appointment packages. I have 60 days to elect additional optional life insurance unless a prior election
remains in force. Basic premiums for Life Insurance will be withheld from my pay unless I submit a waiver (SF2817)
before the 15th of the month. I have 60 days from the date of my appointment to apply for abbreviated underwriting
under the Federal Long Term Care (LTC) Insurance Program. I have 60 days from the date of my appointment to
apply for the Flexible Spending Accounts (FSAFEDS), or the Dental & Vision Insurance Program (FEDVIP) programs.



Signature (Required for Appointment)

Date

E. WORKERS COMPENSATION INFORMATION:



I ☐ have ☐ have not, received or made application for loss wage compensation under the Federal Employees
Compensation Act (job-related injury).

If you have, show: Claim Number _____ Period of Compensation – From: _____ To: _____

SSN: _____

F. PREVIOUS FEDERAL CIVILIAN SERVICE:

1. House of Representatives Yes No If Yes, last termination date _____
2. Other Federal Civilian Service Yes No If Yes, last termination date _____

3. PLEASE LIST BELOW ALL PRIOR FEDERAL CIVILIAN SERVICE: **Include the Senate, Architect of the Capitol, the District of Columbia or a Non-Appropriated Fund Instrumentality (NAFI). (Do not include unpaid internships). (Do not include Active Duty Military Service - See Section 5 below).**

Department or Agency	Date Appointed	Date Separated

Last Personnel Office Phone Number _____

4. While employed as above, my benefits status was:

- (a) Federal Employees' Health Benefits (FEHB) / Health Exchanges:

☐ Enrolled (FEHB) _____ Enrollment Code (FEHB) Not Enrolled (FEHB) | Health Exchange ☐ Excluded

- (b) Federal Employees' Life Insurance: Basic A B _____ x Times Did You Port Option B? ☐ Y ☐ N
C _____ x Times Waived Excluded

- (c) Do you have a FEGLI court order on file? Yes No

- (d) Covered by: ☐ FICA ☐ FICA/FERS ☐ FICA/FERS RAE ☐ FICA/Furt RAE ☐ FICA/CSR Offset ☐ CSR only
Transfer to FERS: ☐ Yes ☐ No

Thrift Savings Plan employee contribution: \$ _____ or _____ %

TSP 50+ Catchup Contribution \$ _____

Do you have a current TSP Loan? Yes If Yes, loan payment amount _____ No

- (e) Refund of CSR contributions: Yes Date of Refund: _____ No

- (f) Federal Long Term Care (LTC) Program

If you currently have LTC and are paying by payroll deduction, the House does not currently provide payroll deduction option for this benefit and you must arrange for an alternative form of payment.

5. Active Military Service - Branch: _____ From: _____ To: _____

(a) Are you returning from Active Military Service which interrupted your Federal Civilian Service? Y N

6. Other Names Used (if different from your present signature): _____

7. I took a Voluntary Separation Incentive. Yes No

G. PENSION BENEFITS:

I am am not, receiving a pension annuity, or retired pay from the United States Government. (If Yes, please furnish source and claim number below.) **Type of Payment:**

Civil Service/FERS/FERS RAE/Furt RAE: Claim Number _____ Retirement Date _____

Alternative Form of Annuity (AA) Lump Sum

Military Retiree's Pay-Branch of Service _____ Rank _____ Retirement Date _____

Veteran's Benefit: Combat Related Yes No

Social Security Foreign Service CIA DC Police or Firefighter's Benefit Other _____

H. CERTIFICATION:

I certify, under penalty of law, that the information provided above is correct and complete.



Signature (Required for appointment) _____

Date _____

FINANCE AND PAYROLL USE ONLY

Life Insurance: Basic ___ Opt. A ___ Opt. B ___ (x times) Opt. C ___ (x times) Waiver ___ Excluded ___

FICA ___ FERS ___ FERS RAE ___ Furt RAE ___ CSR/OFFSET ___ CSR ___ Transfer ___ Prior Agency Service ___

Pension Plan ___

TSP ___ % or \$ _____ TSP Loan Pmt. \$ _____ TSP 50+ Catch-up \$ _____

Status Code _____ Status Date _____ All Service SCD _____ TSP SCD _____

Cong. SCD _____ Eligibility Date _____ FEHB/Exchange/Ineligible _____