



# DISTRICT ENROLLMENT FORM

Employee Name - First	Middle	Last
Employee Number	Effective Date	District

Address	City	State	Zip	Home Phone No.
Emergency Contact				Contact Phone No.

Social Security No.

**Federal Withholding Status (attach W-4)**  
 Married     Single     Married @ Single Rate

Federal Withholding Exemption(s)

Additional Withholding per Pay Period

Wage Rate Per

Hour      Meeting

Month

**Position**  
 Non-Union     Union     Elected

**Health & Welfare Benefits\***

Type of Benefit	Code	Type of Benefit	Code
Medical	<input type="text"/>	Other:	<input type="text"/>
Dental	<input type="text"/>		<input type="text"/>
Vision	<input type="text"/>	Retirement	<input type="text"/>
Life	<input type="text"/>		<input type="text"/>
Life Dependant	<input type="text"/>		<input type="text"/>

Home Fund

Home Cost Center/Department

Date Started

Date of Birth

Gender  Female     Male

Job Title

Work Site

Supervisor

Employment Security  
 Covered (001)     Not Covered (007)    SOC Code

Social Security  
 Covered     Not Covered

**Deductions\***

	Amount Deducted	Effective Date
Dues: <input type="checkbox"/> Initiation	<input type="text"/> /month	<input type="text"/>
<input type="checkbox"/> Monthly	<input type="text"/> /month	<input type="text"/>
Deferred Compensation	<input type="text"/> /month	<input type="text"/>
Financial Institution	<input type="text"/> /month	<input type="text"/>
United Way	<input type="text"/> /month	<input type="text"/>
Other: <input type="text"/>	<input type="text"/> /month	<input type="text"/>

**\*Attach Appropriate Forms**

Workers Comp. Codes:  
 1501 Cemeteries     5306 Clerical     1507 Water     Other:

Comments:

Commissioner	Date	Prepared By	Date
Commissioner	Date	Input By	Date