CANYON-OWYHEE SCHOOL SERVICE AGENCY #555

109 Penny Lane – Wilder, Idaho 83676-5207
www.cossaschools.org
Phone (208) 482-6074 – Fax (208) 482-7904

Congratulations on your new job with Canyon-Owyhee School Service Agency (COSSA). We are glad that you have chosen to become a part of our team! This packet contains all of the information required by law and needed to establish an employee record for you in the payroll system. The COSSA Human Resources Department is responsible for creating and maintaining an employee record for every COSSA employee. In order to set up a payroll and benefit record, certain information protected under the Privacy Act of 1974 must be collected. The information collected will be used solely for the purposes of creating the employee record. COSSA is required by law to protect the privacy of your information and may not use the protected information for any purposes other than what is stated herein without your written permission. Please use your legal name and not a nickname when filling in your information.

PLEASE READ THE FOLLOWING CAREFULLY

1. The second page of this document is a fillable form that will automatically fill in the repetitive information that is asked for throughout the documents. Please fill out completely.
2. You will need to scroll through each of the documents to check for information and boxes that need to be filled out separately to insure that all of the pertinent information has been filled in.
3. After all of the forms are completed to your satisfaction you can then print the forms front-to-back to physically sign and turn in to the Human Resource Department. At that time you will also need to bring in your Driver's License, Social Security Card or Certified Birth Certificate and any original college or university transcripts if applicable.
4. Regarding Health Insurance, you will need to either turn in a Blue Cross Waiver form for waiving the available insurance or The Blue Cross Enrollment form for enrolling in a plan, not both.

Please let us know if you have any questions and feel free to visit our website where you can view and print other employee forms and information as needed: https://www.cossaschools.org/employee-forms

Again, welcome to Canyon-Owyhee School Service Agency and have a great school year!

Sincerely,

Miren Lowry & Mandy Pascale
COSSA Human Resource Department

First Name

Middle Name

Last Name

First Name & Last Name

Middle Initial

Full Legal Name

Social Security Number

Date of Birth (mm/dd/yy)

Today's Date

Job Title

Blank

Building Location -select one

Work Phone

Email Address

Hire Date

Blank

Gender

Physical Address

City, State Zip (physical)

City

State Abbreviation

Zip

Home Phone

Mailing Address

City, State Zip

City

State Abbreviation

Zip

Cell Phone

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS Form I-9

OMB No.1615-0047

Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the Instructions.

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)

Address (Street Number and Name)	Apt. Number (if any)	City or Town	State	ZIP Code

Date of Birth (mm/dd/yyyy)	U.S. Social Security Number	Employee's Email Address	Employee's Telephone Number

I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.

Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):

- ☐ 1. A citizen of the United States
- ☐ 2. A noncitizen national of the United States (See Instructions.)
- ☐ 3. A lawful permanent resident (Enter USCIS or A-Number.)
- ☐ 4. A noncitizen (other than **Item Numbers 2.** and **3.** above) authorized to work until (exp. date, if any)

If you check **Item Number 4.**, enter one of these:

USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance

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

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the Preparer and/or Translator Certification on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	OR	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					

Additional Information

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.

First Day of Employment (mm/dd/yyyy):

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code

For reverification or rehire, complete Supplement B, Reverification and Rehire on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.
* Documents extended by the issuing authority are considered unexpired.
Employees may present one selection from List A or a
combination of one selection from List B and one selection from List C.
Examples of many of these documents appear in the Handbook for Employers (M-274).

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
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: **(1)** NOT VALID FOR EMPLOYMENT **(2)** VALID FOR WORK ONLY WITH INS AUTHORIZATION **(3)** VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: **(1)** The same name as the passport; and **(2)** An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** U.S. Citizen ID Card (Form I-197)
		6. Military dependent's ID card		**6.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Employment authorization document issued by the Department of Homeland Security For examples, see **Section 7** and **Section 13** of the M-274 on **uscis.gov/i-9-central**. The Form I-766, Employment Authorization Document, is a List A, **Item Number 4.** document, not a List C document.
		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		
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				

Acceptable Receipts

May be presented in lieu of a document listed above for a temporary period.
For receipt validity dates, see the M-274.

• Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee.	**OR**	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on **I-9 Central** for more information.

Supplement A, Preparer and/or Translator Certification for Section 1

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

USCIS Form I-9 Supplement A
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

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			Date *(mm/dd/yyyy)*
Last Name *(Family Name)*	First Name *(Given Name)*		Middle Initial *(if any)*
Address *(Street Number and Name)*	City or Town	State	ZIP Code

Supplement B,
Reverification and Rehire (formerly Section 3)

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

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 07/31/2026

Last Name *(Family Name)* from **Section 1.**	First Name *(Given Name)* from **Section 1.**	Middle initial (if any) from **Section 1.**

Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

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

Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.

Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*

Additional Information (Initial and date each notation.)

☐ Check here if you used an alternative procedure authorized by DHS to examine documents.

COSSA Human Resources Office
109 Penny Lane, Wilder, ID, 83676
(208) 482-6074 • Fax: (208) 482-7904
http://www.cossaschools.org

DIRECT DEPOSIT AUTHORIZATION

Use this form to add or change a direct deposit. A direct deposit requires net pay to be deposited into one account. Most financial institutions (banks) are set up to receive direct deposits. ***It is the employee's responsibility to make sure the financial institution will accept it.***

I hereby authorize Canyon-Owyhee School District , hereinafter called Employer, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entries on error to my checking account and the depository named below, hereinafter called Depository, to credit and/or debit the same to such account (**circle one below**):

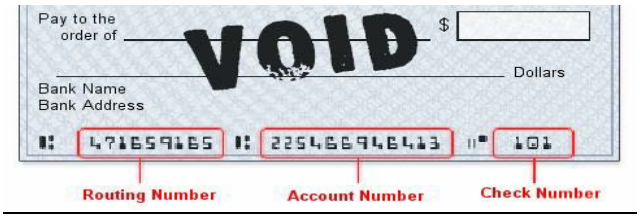
NEW ACCOUNT CHANGE ACCOUNT

Depository (Bank) Name_____Branch_____

Address_____

City_____State_____Zip_____Phone_____

9 Digit Transit Routing No._____Account No._____



Amount: ☐ **$**_____ **or** ☐ **Entire Paycheck**

This authority is to remain in full force and effect until the employer has received written notification from the employee of its termination in such time and such manner as to afford the employer and depository a reasonable opportunity to act on it. Deposits returned because of a closed account or incorrect information provided by the employee will result in the employee's pay being charged for any related bank charges and a delay in receiving their paycheck.

Employee Name_____**Signature**_____

Date_____

Please return this authorization to: **COSSA Human Resource Office @ District Office**

MUST SUBMIT NO LATER THAN THE 5TH OF THE MONTH IT IS TO TAKE EFFECT.

IMPORTANT! CHECK TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

PLEASE ATTACH A VOIDED CHECK HERE

(A voided check is required for verification of the account & routing number)

CANYON-OWYHEE SCHOOL SERVICE AGENCY #555

109 Penny Lane – Wilder, Idaho 83676-5207
www.cossaschools.org
Phone (208) 482-6074 – Fax (208) 482-7904

STAFF DATA FORM

Complete all sections of this form. *The information requested is required by law and needed to establish an employee record for you in the payroll system. The COSSA Human Resources Department is responsible for creating and maintaining an employee record for every COSSA employee in the 2M Data HR/payroll database. In order to set up a payroll and benefit record, certain information protected under the Privacy Act of 1974 must be collected. The information collected on the Staff Data Form will be used solely for the purposes of creating the employee record. COSSA is required by law to protect the privacy of your information and may not use the protected information for any purposes other than what is stated herein without your written permission.*

GENERAL INFORMATION

EMPLOYEE'S FULL LEGAL NAME:_____ **GENDER:** Blank

PHYSICAL ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

MAILING ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

EMAIL ADDRESS:_____

HOME PHONE:_____ **MOBILE PHONE:**_____ **WORK PHONE:**_____

MARITAL STATUS: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Seperated** ☐ **Widowed/Widower**

SPOUSE'S NAME:_____

EMERGENCY CONTACT INFORMATION #1

NAME:_____ **RELATIONSHIP TO EMPLOYEE:**_____

PHYSICAL ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

HOME PHONE:_____ **MOBILE PHONE:**_____ **WORK PHONE:**_____

EMERGENCY CONTACT INFORMATION #2

NAME:_____ **RELATIONSHIP TO EMPLOYEE:**_____

PHYSICAL ADDRESS:_____

CITY:_____ **STATE:**_____ **ZIP CODE:**_____

HOME PHONE:_____ **MOBILE PHONE:**_____ **WORK PHONE:**_____

RACE AND ETHNICITY

(OPTIONAL. IF YOU CHOOSE TO ANSWER, ANSWER BOTH PART A AND PART B)

Please note – if you choose not to complete this section, we will either use the existing information contained in your file or a designated school staff person(s) will observe and select racial and ethnic categories on your behalf, as required by the Federal government for aggregate reporting.

ARE YOU HISPANIC/LATINO?	
Part A **(choose only one)**	☐ **NO, not Hispanic/Latino**
	☐ **YES, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
If you answered yes, skip Part B; if you answered no, please answer Part B.	
WHAT IS YOUR RACE?	
Part B **(choose one or more)**	☐ **American Indian or Alaskan Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)
	☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
	☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
	☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
	☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

I certify that the information contained herein is true and correct to the best of my knowledge.

Employee Signature _____ **Date** _____

Return form to the Human Resources Department at the District Office
109 Penny Lane, Wilder, ID 83676 ~ Phone: (208) 482-6074 ~ Fax: (208) 482-7904
THANK YOU!

BUILDING ACCESS CODE and KEY AGREEMENT

REQUESTORS NAME: _____BUILDING: CRTEC Facility

Person requesting Access Code/Alarm Code/Key: Please complete this page, sign, and submit to the COSSA Human Resources Office.

In an effort to promote safety and security for Canyon-Owyhee School Service Agency and its facilities, persons working must be pre-approved by the COSSA Human Resources Department through Administration, and, if issued an Access Code, an Alarm Code, and/or Key, immediately report to the COSSA Safety Coordinator if it is lost, stolen, damaged, or compromised.

Building entryways/doors are normally locked at all times. Access to District buildings may be digitally recorded and closely monitored (including via video surveillance) by the COSSA Safety Coordinator, School Resource Officers & Administration.

Access Codes/Alarm Codes/Keys provide authorized users access through the primary doors. No person is allowed to enter school buildings without an Access Code/Alarm Code/Key.

In order to be issued a Building Access Code/Alarm Code/Key, you must complete and sign the following section and submit it to the COSSA Human Resource Office.

I understand my Access Code, Alarm Code, and/or Key is for building access purposes only.
I understand my Access Code, Alarm Code, and/or Keyis nontransferable.
I understand I will not share my Access Code, Alarm Code, and/or Key with other persons. Any person attempting to gain access to a building with another authorized user's Access Code, Alarm Code, and/or Key will be subject to disciplinary action, including possible termination of Access Code, Alarm Code, and/or Key privileges
I understand that my Access Code, Alarm Code, and/or Key is the property of Canyon-Owyhee School Service Agency. If I lose , damage, or compromise my Access Code, Alarm Code, and/or Key, I will report it immediately to the COSSA Human Resource Office.
I understand that I will pay a $5.00 fee, via check or cash, in order to receive a replacement Key and that additional fees may be charged to me should it be necessary to re-key or replace lock(s).
I understand that I am required to return my Key to either the COSSA Human Resources Office or COSSA Safety Coordinator upon my transfer to another building, separation from employment, or completion of my contract/job.

☐ **I UNDERSTAND AND AGREE TO FOLLOW THE ABOVE TERMS**

_____ _____
Signature of Person Requesting Access Code, Alarm Code, and/or Key Date

07/2018

Cossa Human Resource Office
109 Penny Lane, Wilder, ID, 83676
(208) 482-6074 • Fax: (208) 482-7904
http://www.cossaschools.org

Personal Liability Insurance Acknowledgment

This is to acknowledge that I have been provided information regarding professional liability insurance in compliance with Title 33-524, Idaho Code, in which school districts shall provide information to their employees (all certificated and noncertified staff) regarding professional liability insurance for educators. A list of providers can be found on the COSSA website and can be accessed at https://docs.wixstatic.com/ugd/a04748_3c24ec0c68504b719177e7505d18bb0a.pdf

Personnel Handbook Acknowledgment

This is to acknowledge that I have been advised of the web-based Canyon-Owyhee School Service Agency Personnel Handbook which can be accessed on the COSSA web page at www.cossaschools.org

I hereby acknowledge receipt of the COSSA Personnel Manual (a copy of the Personnel Handbook is posted on the COSSA website for all employee and stakeholder review). I realize that the manual contains agency policies and procedures, but is not intended to be a complete and exhaustive explanation of the same. I also understand that said policies and procedures are subject to change; that I am to familiarize myself with its contents; and that I am to abide by the policies and procedures stated herein and of the agency. Complete COSSA Policies are available for review at the COSSA Administrative Office and are additionally posted on the COSSA website.

I further understand and agree that this manual does not constitute a contract of employment.

The policies and procedures described in this manual may be revised from time to time through the discretion of the COSSA Board of Trustees. Copies of individual policies and procedures may be printed directly from the website, requested from an administrator, or requested from the COSSA Human Resources Office.

COSSA employees will take a Personnel Handbook lesson and quiz annually using the SafeSchools training platform.

COSSA would like all employees to be familiar will all policies and procedures but especially aware of:

Policy 111 - Parental Rights
Policy 113 - Student and Family Privacy
Policy 116 - Public Records Request
Policy 210 - Employee Purchase
Policy 309 - Sick Leave Bank
Policy 310 - Family and Medical Leave
Policy 311- Sexual Harassment
Policy 8200 - Wellness

Policy 313 - Drug Free Workplace
Policy 406 - Student First Aid
Policy 415 - Service Animals
Policy 420 - Safe Environment
Policy 421 - Students with Head Lice
Policy 5210 - FLSA and Work Day
Policy 5250 - Certified Personnel Grievance
Policy 5800 - Classified Personnel Grievance
Policy 7235 - Time and Effort

_____
Employee's Signature

_____
Date

_____
Employee's Printed Name

CANYON-OWYHEE SCHOOL SERVICE AGENCY (COSSA)

INSURANCE BENEFIT

Acknowledgment

School Year: 2024-2025

In compliance with the Affordable Care Act (ACA) passed by Congress and signed into law in 2010, Canyon-Owyhee School Service Agency is required to provide a Summary of Benefits and Coverage (SBC) and Glossary of Health Coverage and Medical Terms to all employees. A copy of each of these is available to all employees online at www.cossaschools.org.

In compliance with the Affordable Care Act (ACA) and by my signature below, I verify that I have been informed and received information regarding health coverage options by Canyon-Owyhee School Service Agency, and I acknowledge that Canyon-Owyhee School Service Agency has disclosed to me the attached Summaries of Benefits and Coverage (SBC's) for each available option and the attached Glossary of Health Coverage and Medical Terms, as required by law.

_____ _____

Signature Date

Print Name:_____

Blue Cross of Idaho

Employee's Waiver of Health Care Coverage

If you decline to enroll either yourself or your eligible family members in the health care coverage offered by your employer, we ask that you complete this form. **Qualified late enrollees who decline coverage may not reapply for coverage until their employer's policy renewal date.**

MEDICAL:

I certify that I have been informed of the availability of coverage under my employer's health benefit plan, but I choose not to enroll *(please check all that apply and list each eligible family member's name)*:

☐ myself ☐ my eligible child(ren): _____

☐ my spouse: _____

I have chosen to decline health care coverage at this time because:

☐ I and/or my dependents have other group or individual coverage with *(name of insurance company)* _____

through *(insured's name and relationship)* _____

☐ Is your current employer contributing toward your other coverage? ☐ Yes ☐ No

☐ Other reason(s) to waive coverage *(please specify)*: _____

DENTAL:

I certify that I have been informed of the availability of coverage under my employer's Affortable Care Act (ACA) qualified dental plan for members under age 19, but I choose not to enroll because I and/or my dependent(s) have group or individual coverage in a qualified dental plan with *(name of insurance company)* _____ _____

through *(insured's name and relationship)* _____

I understand that if, at this time, I decline coverage offered by my employer for myself or my eligible family members, and then choose to apply for coverage later, the opportunity will be limited to open enrollment, except in the following instances:

1. The individual meets each of the following:
   a. The individual was covered under qualifying previous coverage at the time of the initial enrollment;
   b. The individual lost coverage under qualifying previous coverage as a result of termination of employment or eligibility, the involuntary termination of the qualifying previous coverage;
   c. The employer stops contributing towards your or your dependents' other coverage; and
   d. The individual requests enrollment within 30 days after termination of the qualifying previous coverage.
2. The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period;
3. A court has ordered that coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or
4. If an individual seeks to enroll a dependent during the first sixty (60) days of eligibility, the coverage of the dependent shall become effective:
   a. in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;
   b. in the case of a dependent's birth, as of the date of such birth; or
   c. in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

Please print name	*Name of group*
Social Security number	*Group number*
Employee's signature *Date*	*Group administrator's signature* *Date*

Blue Cross of Idaho

Statewide Schools ASC Health/Dental/Vision Enrollment Application

Requested Effective Date (subject to Blue Cross of Idaho approval) ____________

Group Number 10003727-R005

❑ **PPO Medical** 1000/2000 Option 1
❑ HSA BlueSM Option 2
❑ Managed Care Medical POS

❑ **Dental Blue Connect**
❑ PPO Dental
❑ **Vision**

Please complete each section of this application in ink.

Applicant Information (Employee)

Your Name (first, initial, last)	Blue Cross ID No. (if currently enrolled)	Social Security No.	Date of Birth	❑ Male ❑ Female
Mailing Address	City, State, Zip Code		Phone Number	
Marital Status ❑ Single ■ Married ❑ Divorced ❑ Widowed	Full-time Hire Date	Name of Employer: CANYON-OWYHEE SCHOOL SERVICE AGENCY	Job Title	Email Address

Dependent Information (If you choose not to enroll all your eligible family members, you must complete a waiver form.)

List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Male/Female	Type of Enrollment
Applicant/Employee		**SELF**		❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No / *Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No / *Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No / *Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No / *Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No / *Office Use (PCP)*
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female	Enroll in Medical ❑ Yes ❑ No Enroll in Dental ❑ Yes ❑ No Enroll in Vision ❑ Yes ❑ No
For Managed Care Plans Only	Name of Primary Care Physician (PCP) or PCP ID Number (For the highest benefit level, you must select a PCP)				Existing Patient? ❑Yes ❑ No / *Office Use (PCP)*

Type of Enrollment

Health Coverage *(check one)*	**Dental Coverage** *(check one)*	**Vision Coverage** *(check one)*
❑ Self only	❑ Self only	❑ Self only
❑ Self and spouse	❑ Self and spouse	❑ Self and spouse
❑ Self, spouse and dependents	❑ Self, spouse and dependents	❑ Self, spouse and dependents
❑ Self and one dependent	❑ Self and one dependent	❑ Self and one dependent
❑ Self and two or more dependents	❑ Self and two or more dependents	❑ Self and two or more dependents

Change Request

Please indicate reason for change in current enrollment below:

❑ Involuntary loss of group coverage ❑ Marriage ❑ Birth ❑ Adoption

❑ Court order (copy of court order required)

Other New Hire

Date event occurred ____________
mm dd yy

Please read the reverse side and sign and date this application. **OVER ☛**

FOR OFFICE USE ONLY

Group Number	*Subgroup*	*Effective Date*	*Plan ID M*	*Plan ID D*	*Plan ID V*	*Class*	*Reason Code*

Auditor ________

3000 E. Pine Ave. • Meridian, Idaho 83642 • 208-345-4550
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

Disability Information

Are you or any of your dependents currently disabled? ❑ **YES** ❑ **NO**

Nature of Disability

Name of Disabled Person

Physician's Name *Physician's Phone Number*

Date of Disability

Physician's Address

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- I agree to abide by all of the terms and conditions of the group policy.
- No independent producer, agent or employee of Blue Cross of Idaho, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- Blue Cross of Idaho may terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***bcidaho.com.***
- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of Blue Cross of Idaho.
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

X *Applicant's Signature*

Date

Beneficiary Designation

Purpose of the Form

- Use this form to designate beneficiaries to receive your PERSI Base Plan and Choice 401(k) Plan death benefits.

  Note: For purposes of your death benefits, the designation(s) in this form supersede all other arrangements, and will be honored regardless of those arrangements, including a last will and testament or trust document. However, death benefits are still subject to community property law.

Instructions

- Read **About Form RS115**, attached.

Note: If your address has changed, you must submit form RS110, *Member Mailing Address Change*, with this form.

Member Social Security Number	Member PERSI ID Number*

* *A PERSI ID is only required for members with multiple PERSI accounts.*

Member Information

Name – First, Middle, Last			
Mailing Address	**Street or P.O. Box**		
	City	**State**	**Zip Code**
Daytime Phone Number (include area code)	**Email Address**	**Marital Status** ☐ Single ☐ Married	

Primary Beneficiary or Beneficiaries

Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
				.0%	☐ Check this box and go to page 2.
				.0%	☐ Check this box and go to page 2.
				.0%	☐ Check this box and go to page 2.
				.0%	☐ Check this box and go to page 2.

Secondary Beneficiary or Beneficiaries

Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
				.0%	☐ Check this box and go to page 2.
				.0%	☐ Check this box and go to page 2.
				.0%	☐ Check this box and go to page 2.
				.0%	☐ Check this box and go to page 2.

Member Acknowledgment

I understand the instructions and information under "About Form RS115." I revoke all previous PERSI beneficiary designations and request that any PERSI benefits payable after my death be made as indicated herein. I may change this designation by filing a new form. This designation applies to my PERSI Base and Choice 401(k) Plan accounts.

Signature	Date – mm/dd/yyyy

Public Employee Retirement System of Idaho
P. O. Box 83720, Boise, ID 83720-0078
1-800-451-8228 • 208-334-3365 • Fax 208-334-3805
www.persi.idaho.gov • frontdesk@persi.idaho.gov

Beneficiary Designation (continued)	
Member Name – First, Middle, Last	**Social Security Number**

Custodian Nominations for Minor Beneficiaries under the Idaho Uniform Transfers to Minors Act

- Use this section to nominate custodians and substitute custodians for minor beneficiaries under the Idaho Uniform Transfers to Minors Act. Attach a copy of this page if nominating custodians for more than 4 minor beneficiaries.

Instructions

- Write the minor beneficiary's name in the top box.
- Write the custodian's name, Social Security number, address, and telephone number in the appropriate boxes. You can nominate a substitute custodian to serve in the event the nominated custodian is unable. List each minor beneficiary separately, even if you are nominating the same custodian for all minor beneficiaries.

Minor Beneficiary Name:

Custodian Information		Substitute Information	
Name:		**Name:**	
SSN:		**SSN:**	
Address:		**Address:**	
City, St, Zip:		**City, St, Zip:**	
Telephone:		**Telephone:**	

Minor Beneficiary Name:

Custodian Information		Substitute Information	
Name:		**Name:**	
SSN:		**SSN:**	
Address:		**Address:**	
City, St, Zip:		**City, St, Zip:**	
Telephone:		**Telephone:**	

Minor Beneficiary Name:

Custodian Information		Substitute Information	
Name:		**Name:**	
SSN:		**SSN:**	
Address:		**Address:**	
City, St, Zip:		**City, St, Zip:**	
Telephone:		**Telephone:**	

Minor Beneficiary Name:

Custodian Information		Substitute Information	
Name:		**Name:**	
SSN:		**SSN:**	
Address:		**Address:**	
City, St, Zip:		**City, St, Zip:**	
Telephone:		**Telephone:**	

Public Employee Retirement System of Idaho
P. O. Box 83720, Boise, ID 83720-0078
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Standard Insurance Company **Beneficiary Designation/Change**

This designation will apply to the following Standard Insurance Company coverage(s) if available to you through your Employer: Life Insurance, Life with Accidental Death & Dismemberment (AD&D) Insurance, AD&D Insurance and, unless specified otherwise on a separate signed sheet of paper, Supplemental Life Insurance.

Designations made below, or on a separate sheet of paper, are not valid unless signed, dated, and delivered to your Employer during your lifetime. Return the completed form to your Human Resources Department.

MEMBER/EMPLOYEE INFORMATION

Your Name (Last, First, Middle)		Date of Birth
Your Address		
City	State	Zip
Group Name Canyon-Owyhee School Service Agency	Group No. 00 475128 0001	

BENEFICIARY INFORMATION

- Your designation revokes all prior designations.
- Benefits are payable to a contingent Beneficiary only if you are not survived by one or more primary Beneficiaries.
- If you name two or more Beneficiaries in a class (primary or contingent), two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

  If a minor (a person not of legal age) or your estate is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated_____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance and Supplemental Life Insurance on your Spouse, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If you complete the "% of Benefit" box(es), the amounts should add up to 100% for each class (primary or contingent). For example, "Primary - John Q. Doe, 60%; Jane Q. Doe, 40%."

PRIMARY – Full Name	Address	Date of Birth	Phone No.	Relationship	% of Benefit

CONTINGENT – Full Name	Address	Date of Birth	Phone No.	Relationship	% of Benefit

Signature of Member/Employee _____ Date _____

Human Resources Department – Retain for your records.

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:

  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.

CANYON OWYHEE SCHOOL SERVICE AGENCY
Section 125 Plan
Interest Form for New Employees

Please mark the appropriate line and/or boxes and return to Payroll/Benefits Office:

☐ **I would like more information about pre-taxing my benefits under the Section 125 Plan.**

☐ **I would like information about the following benefits.**

- ☐ Accident Only Insurance*,+
- ☐ Cancer Insurance*,+
- ☐ Disability Income Insurance*
- ☐ Life Insurance*,**
- ☐ Annuities**

☐ **I would like more information on the following reimbursement accounts available through Section 125:**

- ☐ Healthcare Flexible Spending Account maximum $2,700/plan year.
- ☐ Dependent Care Flexible Spending Account maximum $5,000/plan year.+++
- ☐ Health Savings Account maximum $3,500 individual, $7,000 family.

** These products may contain limitations, exclusions, and waiting periods.*
*** Not generally qualified benefits under Section 125 Plans.*
*+ **This product is inappropriate for people who are eligible for Medicaid coverage.***
+++ Maximum $2,500 if you are married and file a separate tax return.

I'd like American Fidelity Assurance Company to contact me about benefits. With my signature below, I understand that someone will call me to discuss my options and/or schedule my appointment.

Print Name

Signature*

Job Location

Blank

Classified/Certificated/Management

Blank

Phone

Email Address

Date of Hire

*With my signature, I consent to being contacted, including by phone, regardless of my status on any do not call list.

Katherine Hamilton
Senior Account Manager
Northwest Area Branch Office
325 E. Shore Drive, #110
Eagle, ID 83616
877-589-2544
americanfidelity.com

AMERICAN FIDELITY
a different opinion

CANYON-OWYHEE SCHOOL SERVICE AGENCY
109 Penny Lane
Wilder, ID 83676
Phone (208) 482-6074
Fax (208) 482-7904

Patricia Frahm, CEO;
Tammie Anderson, Special Education Director;
Miren Lowry, Business Manager,
Clerk of the Board

Background Investigation Check
CRIMINAL HISTORY
PAYROLL DEDUCTION AUTHORIZATION

I _____ , hereby authorize the Canyon-Owyhee
Print Name
School Service Agency to make a payroll deduction in the amount of $28.25 to cover the cost of the Idaho Criminal History Check to process criminal history FBI fingerprints, as required by Idaho code:33-152.

_____ ____ _____
First Name *MI* *Last Name*

_____ _____
Signature *Date*

Canyon-Owyhee School Service Agency (COSSA) is a public school cooperative serving the special education, gifted/talented, career & technical, and alternative education needs of students from Homedale, Marsing, Notus, Parma, and Wilder School Districts.

CEA Membership

Name: _____

☐ Yes, I would like to join COSSA Education Association. I agree to have the $10.00 dues deducted (one time) from my paycheck.

☐ No, I am not interested at this time.

_____ _____

Signature Date

CEA SCHOLARSHIP
PAYROLL DEDUCTION FORM

I (print name) _____ would like to support the COSSA Education Association (CEA) scholarship fund by donating through an automatic payroll deduction as follows:

Monthly (amount) _____ One-time donation (amount) _____

_____ _____
Signature Date