

DIOCESE OF LAKE CHARLES

FISCAL PROCEDURE MANUAL

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DIOCESE OF LAKE CHARLES PROCEDURES AND INFORMATION MANUAL

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SECTION I

DIOCESAN PROCEDURES

Diocese of Lake Charles

Procedures Manual

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Basic Internal Controls

Internal control is the church's check and balance system. Good internal controls can assist you, the pastor, in your responsibility of good stewardship. A system of internal control should be established to reduce the potential of fraud, misstatement of accounts in the financial statements, and to maintain accountability. At the very least you should establish procedures to protect assets (cash, investments and property) and to ensure that the accounting records are accurate and complete. Below are some very basic guidelines to consider in establishing basic internal controls.

Separation of duties

- No one person should control a transaction from beginning to end. In a small "shop," more oversight from management is needed over the accounting activities. (See Appendix A-Segregation of Duties)

Cash Controls

- Please note that no one person should ever count the collection money alone. Two people (on a rotation basis should count and verify in writing) the Sunday collections. It should be construed as a suspicious activity if one person always insists on counting the collection alone.
- Cash collected should be deposited daily.
- A pre-numbered cash receipts book (in triplicate) should be utilized. One copy for the customer, one for the deposit summary and one for the book.
- No one person should have control of cash (see collection procedures).
- Check signing should be the responsibility of an individual having no access to the accounting records.
- Payment for goods or services should be supported by invoice (and not by statements) -this helps to avoid double payments.
- Petty cash should be minimal and be reflected in the accounting records.
- Checks should never be made out to "cash."
- When the pastor signs checks, he should review the supporting documentation, such as invoices (which should be attached to the check for his review.)

Bank accounts and accounting records

- The number of bank accounts should be strictly limited to those absolutely required. The fewer the account, the greater the control.
- Authorized check signers should be very limited. Checks over a certain amount should be signed by two individuals. No signature stamp should be allowed.
- Bank accounts should be reconciled (all bank accounts and investment accounts) and reviewed by the pastor on a monthly basis - question old outstanding items.
- Parish financial statements should reflect the cash on hand. Statements should be reviewed by more than one individual. One individual should never control a

bank account. Copies of bank statements should be turned in to the fiscal department on a monthly basis. There have been many instances of bank statements not turned in to the Fiscal office - this results in a misstatement of the parish's financial records. Please note that deliberate misstatement of financial statements is a red flag that can indicate fraud.

- There seems to be some confusion about when to obtain a form W-9. IRS regulations require form 1099 Misc. to be sent to individuals and unincorporated business with payments made to them over \$600 in one year. In order to comply with these regulations and avoid penalties, you should request a form W-9 from your vendors and other individuals immediately (as soon as work is performed and before the first check is issued) in order to avoid burdensome recordkeeping and IRS penalties. As a reminder-please make checks to religious priests, sisters and brothers payable to their order. We have noticed many checks lately being issued to these individuals instead of the order. These will be reported to the IRS and may cause some problems with the individual priests or sisters.

Payroll

- All payroll records should be supported by timesheets.
- The person who is responsible for preparing checks and summarizing payroll data should not sign or distribute the payroll checks.
- 941's (IRS quarterly reports) are due April 30, July 31, October 31, and January 31. Any report turned in late is a red flag to the IRS (IRS considers this sloppy recordkeeping, subject to penalty). I have noted instances in which these reports are turned in late to the IRS due to bookkeepers turning their work in late. Please note that the parish books (from the previous month) are due in to the Fiscal office by the 10th of the month (or soon thereafter). Many parish books are turned in much later-at the end of the month, which almost ensures a late quarterly report.
- All employees should be paid by checks. There have been instances when employees or part time employee's request to be paid by cash because they are on "social security or disability." Please be aware that if this occurs, the parish is colluding with the employee to defraud the Internal Revenue Service. "Under the table" transactions are red flags indicating fraud. (This is also true when individual vendors request to be paid in cash or refuse to sign a W-9.) Let me warn you that your Parish, perhaps the Diocese and in some instances, you personally, can be liable for huge penalties and interest for any taxes not withheld or improperly withheld.

Procedures for Handling Weekly Collections

Strong internal control procedures must be implemented by the parishes to provide reasonable assurance against misappropriation of money collected. Pastors must take the appropriate precautionary steps to safeguard the parish's assets-this is an important administrative responsibility in keeping with the role of good stewardship. The following are procedures to that can serve as a deterrent to those who may otherwise have access to cash.

1. After the collection is passed throughout the congregation, two or more ushers place the collection in a locked bag at the vestibule. The key to the locked bag should be in the possession of the head money counter who does not gain access to the collection until Monday morning when he/she is accompanied by other counters. Bags must be the type that can be locked without using a key.
2. Once the collection is placed in the bag and locked, it is then either placed directly in the vault/locked storage area or is presented to the priest during the offertory procession.
3. Once the mass has concluded, the collection must not be unattended at any time. At least two ushers must be present until such time as the priest takes the collection to the vault or safe. At that time, at least two ushers are to accompany the priest until such time as the locked collection bag is placed in safekeeping (either the vault or safe).
4. If practical, the collections should be placed in the night depository at the bank servicing the parish. Counters should prepare the deposit as in steps 6 and 7. If this procedure is not practical, the collection must be placed in the parish vault or safe that remains locked at all times. The parish vault or safe should be fireproof. Limited access to the vault or safe must be maintained and by no means can the key holder have sole access to the safe or vault.
5. If the collection is placed temporarily in the vault within the church, it must be properly locked during and between masses and access to it must be limited. After the masses have concluded for the day, the priest is accompanied by at least two people from the church to the rectory or bank. The locked collection bags are placed in either the bank's night depository or in the administration office vault or safe until the money counters are available on Monday or generally the day after the holy day.
6. After the priest and ushers secure the collection in locked storage, the collection is not touched until Monday morning when at least two money counters are present to prepare the cash receipt. A money counter or staff person without possession of the key to the bag should obtain the collection from the vault/safe while accompanied by another counter or staff. The bag(s) must not be opened until such time as two or more money counters are available for sorting and counting. The head money counter (or other persons with the key to the locked bag) must not have access to the vault/locked storage area where collections are stored. If the collections are brought to the bank prior to counting (using the bank as a safe depository prior to actual deposit), the person with the key must not obtain the bags from the bank.

7. Once the collection is sorted, counted, and the deposit slip is prepared along with the collection accounting form, the deposit must be stored in a different locking moneybag for which only the bank has access to the key. The deposit is brought to the bank for verification and a duplicate deposit slip is prepared. The duplicate deposit slip is returned to the administration office and attached to the collection accounting form previously filled out. The two forms are then submitted to the person in charge of posting the deposit to the parish books.

Please remember to open the envelopes and note the amount on the front of the envelope. Sometimes the amount indicated by the parishioner is not the amount in the envelope.

These procedures are to be followed for second collections. If at all possible and practical, teams of money counters should be scheduled on a rotating basis.

Questions and or comments may be directed to the Business Manager.

Payroll/HR Issues:

Hiring

Personnel File: Every office should have personnel files that should include:

Application (see form section)

Timesheets - Employees should have records of hours worked/days off.

W-4, L-4 (see form section)

I-9: Churches are subject to wage and hour laws as well as immigration and I-9 laws. You must have an I-9 on file for each employee. You must keep records for all non-exempt employees. (See form section)

All employees are to be offered Health insurance and retirement benefits if they work at least 30 hours per week. Please remember that these employees must be paid employees and not volunteers. You should pay at least minimum wage. Wage and hour laws are complex and technical - it's generally safer for churches to follow the laws. It is illegal to put anyone on the insurance that does not work 30 hours a week.

What employment records must I keep?

In general, employers must keep all personnel or employment records for one year. If an employee is involuntarily terminated his/her personnel records must be retained for one year from the date of termination. If a claim of discrimination is filed, all relevant personnel records must be retained until final disposition of the matter. Under ADEA recordkeeping requirements, employers must also keep all payroll records for three years. Additionally, employers must keep on file any employee benefit plan (such as pension and insurance plans) and any written seniority or merit system for the full period the plan or system is in effect and for at least one year after its termination.

Under Fair Labor Standards Act (FLSA) recordkeeping requirements applicable to the EPA, employers must keep payroll records for at least three years. In addition, employers must keep for at least two years all records (including wage rates, job evaluations, seniority and merit systems, and collective bargaining agreements) that explain the basis for paying different wages to employees of opposite sexes in the same establishment.

- Please note that, Bonuses, Commissions, Christmas Bonuses are salary and are subject to all appropriate taxes. These must go through the payroll system. The fines and penalties are harsh for noncompliance. Please also note that these are not charitable donations or public relations expenses.
- Religious communities must receive salaries in the name of the community (even when sub-clergy).

Various Forms:

- HR application, information sheet, L-4, W-4, and I-9
- Blue Cross Forms: Continuing coverage, application, and transfer memo

Termination

You should consult the Diocesan attorney before an employee is fired.

- If an employee is fired, a check must be given to the employee within 72 hours. If an employee quits or is laid off, then we have until the next payday.

Have the employee complete the continuing coverage form.

Have the employee sign the Money Accumulation Pension Plan sheet (see form section).

Brighthouse (Traveler's, MetLife) - Send the correct forms. Explain to employees that the process may take 3-4 months, depending on when the request is made. Anytime an employee leaves, we must know date of termination, current address and whether they want to stay in the plan. Please review the forms and send the proper ones to the Fiscal office.

Health Insurance/Blue Cross

Application Issues

All eligible employees are required to be offered health insurance. An employee is eligible if he or she regularly works 30 hours a week or more. If an employee declines coverage, then they must sign a waiver of enrollment, (backside of application form).

The Fiscal office must receive BlueCross application within 15 days of employment. New Federal regulations will not let us override exceptions as was done in the past. Failure to adhere to this timetable can result in denial of insurance.

The application process for employees who have not previously participated in the plan is still the same. They can apply during the month of June and the effective date of coverage will be July 1; the forms must reach the Fiscal office by June 15. The only exception to this rule is if there has been a new qualifying event (i.e. marriage, new baby, etc.). Please note that Blue Cross must be notified for each qualifying event (such as with a change of status form). If there is any question as to what is an acceptable qualifying event, then please call the BlueCross Office or me before telling the employee that they will be covered. The form(s) for the qualifying event must reach the Fiscal office within 15 days of application date. New Federal regulations will not let us override exceptions as was done in the past. Failure to adhere to this timetable can result in denial of insurance.

Some schools have been sending in their applications when contracts are signed (in May or June), even though date of hire is not usually until August. Blue Cross will deny "post dated" applications. Because insurance is not available until date of hire, the applications should be dated and sent in at date of hire.

Waivers of insurance: All employees who elect not to take insurance must complete a waiver of insurance form --the original must be sent in to the fiscal office.

Payment Issues

BlueCross of Louisiana payments should reach the Fiscal office by the 8th of the month. These are verified by Fiscal and must be received by BlueCross by the 10th of the month.

Credits: If someone quits or terminates insurance, the amount may not be subtracted from the bill; you must pay the bill and a credit will be issued by Blue Cross. Please make sure that you have sent in a Coverage Cancellation Form so that a Credit will be issued.

Retirement

- We have a fiduciary responsibility to invest retirement funds within 30 days. We must turn this in on time. If not in on time interest will be lost on the parish or schools employees account plus we are violating federal regulations and are subject to lawsuits. The Diocese will send the retirement funds on time. If an individual school or parish is late, theirs will be turned in the next month's work.

Any employee who works at least 30 hours a week must be offered participation in one of the Diocesan retirement plans. The employees have two accounts to choose from.

They are briefly described below:

- Fidelity- 1-800-343-0860; identify the Diocese's 403(b) account number- 67409. They employee may chose from a range of investments. Fidelity will send them a packet of information to complete. They must give you the proper information for withholding. Remember that the employees are immediately vested in this plan. This means that the share that the employer contributes belongs to them.
- Brighthouse (MetLife, Travelers)-Have the employee complete the application and forward to the fiscal office. Remember that it takes a full 5 years before the employee is vested in this plan. The employee is given a flat investment rate and no choice of investments.
- Do not steer employees to retirement accounts. It is against the law for you to give investment advice without the proper licensing. You, your church or school and the Diocese could be held liable for a "bad" investment. Mention the vesting differences. I have heard that some are saying the account charges on Fidelity and Merrill Lynch are \$200-\$300 per year. This is incorrect. Fidelity is \$25 annually. Giving out erroneous advice could be considered steering.

Applicable Labor Laws

Fair Labor Standards Act of 1938, as Amended **(29 USC §201 et seq.; 29 CFR 510-794)**

Who is Covered?

The Fair Labor Standards Act (FLSA) establishes minimum wage, overtime pay, recordkeeping and child labor standards that affect over 100 million full- and part-time workers in the private sector and in federal, state and local governments. The Act applies to churches in most cases. The Act is technical and complex and the regulation's text under this act can fill a book an inch thick, so it is best to comply. Moreover for the interest of the social justice issue it is best for the church to comply with the Act.

Some employees are exempt from the Act's overtime pay provisions or both the minimum wage and overtime pay provisions under specific exemptions provided in the law. Because these exemptions are generally narrowly defined, employers should carefully check the exact terms and conditions for each by contacting local offices of the [Wage and Hour Division](#) listed in most telephone directories under U.S. Government, Department of Labor, Wage and Hour Division.

The following are examples of employees exempt from both the minimum wage and overtime pay requirements:

- [Executive, administrative and professional employees](#) (including teachers and academic administrative personnel in elementary and secondary schools), outside sales employees, and certain skilled computer professionals (as defined in Department of Labor regulations);
- Employees of certain seasonal amusement or recreational establishments;
- Employees of certain small newspapers and switchboard operators of small telephone companies;
- Seamen employed on foreign vessels;
- Employees engaged in fishing operations;
- Employees engaged in newspaper delivery;
- Farm workers employed on small farms (i.e., those that used less than 500 "mandays" of farm labor in any calendar quarter of the preceding calendar year);
- Casual babysitters and persons employed as companions to the elderly or infirm;

The following are examples of employees exempt from the Act's overtime pay requirements only:

- Certain commissioned employees of retail or service establishments;
- Auto, truck, trailer, farm implement, boat or aircraft salesworkers, or parts-clerks and mechanics servicing autos, trucks or farm implements, who are employed by

non-manufacturing establishments primarily engaged in selling these items to ultimate purchasers;

- Railroad and air carrier employees, taxi drivers, certain employees of motor carriers, seamen on American vessels, and local delivery employees paid on approved trip rate plans;
- Announcers, news editors and chief engineers of certain non-metropolitan broadcasting stations;
- Domestic service workers who reside in their employer's residence;
- Employees of motion picture theaters;
- Farmworkers.

Certain employees may be partially exempt from the Act's overtime pay requirements. These include:

- Employees engaged in certain operations on agricultural commodities and employees of certain bulk petroleum distributors;
- Employees of hospitals and residential care establishments which have agreements with the employees to work a 14-day work period in lieu of a 7-day workweek (if the employees are paid overtime premium pay within the requirements of the Act for all hours worked over 8 in a day or 80 in the 14-day work period, whichever is the greater number of overtime hours);
- Employees who lack a high school diploma or who have not completed the eighth grade may be required by their employer to spend up to 10 hours in a workweek in remedial reading or training in other basic skills that are not job specific, as long as they are paid their normal wages for the hours spent in such training. Such employees need not be paid overtime premium pay for their remedial training hours.

Basic Provisions/Requirements

The Act requires employers of covered employees who are not otherwise exempt to pay these employees a minimum wage of not less than \$5.85 an hour beginning July 24, 2007, \$6.55 an hour effective July 24, 2008, and 7.25 effective July 24, 2009. Employers may not displace any employee to hire someone at the youth minimum wage.

The Act also permits the employment of certain individuals at wage rates below the statutory minimum wage under certificates issued by the Department:

- Student learners (vocational education students);
- Full-time students in retail or service establishments, agriculture, or institutions of higher education;
- Individuals, whose earning or productive capacity is impaired by a physical or mental disability, including those related to age or injury, for the work to be performed.

The Act does not limit the number of hours in a day or days in a week an employee (at least 16 years old) may be required or scheduled to work, including overtime hours. The Act requires that covered employees, unless otherwise exempt, be paid not less than [one and one-half times their regular rates of pay](#) for all hours worked in excess of 40 in a workweek.

Employers are required to keep [records](#) on wages, hours and other items as set out in the Department of Labor's regulations. Most of this information is of the type generally maintained by employers in ordinary business practice.

Performance of certain types of [work in an employee's home](#) is prohibited under the Act unless the employer has obtained prior certification from the Department of Labor. Restrictions apply in the manufacture of knitted outerwear, gloves and mittens, buttons and buckles, handkerchiefs, embroideries, and jewelry (where safety and health hazards are not involved). Employers wishing to employ homeworkers in these industries are required to, among other things, provide written assurances to the Department that they will comply with the Act's wage and other requirements. The manufacture of women's apparel (and jewelry under hazardous conditions) is generally prohibited, except under special certificates that allow homework in these industries when the homeworker is unable to adjust to factory work because of age or physical or mental disability, or is caring for an invalid in the home.

Special provisions apply to [state and local government employment](#). It is a violation of the Act to fire or in any other manner discriminate against an employee for filing a complaint or for participating in a legal proceeding under the Act. The Act also prohibits the shipment of goods in interstate commerce which were produced in violation of the minimum wage, overtime pay, child labor, or special minimum wage provisions.

Assistance Available

More detailed information on the FLSA, including copies of [explanatory brochures](#) and regulatory and interpretative materials, may be obtained by contacting local [Wage-Hour offices](#) listed in most telephone directories under U.S. Government, Department of Labor, Wage and Hour Division.

The [Fair Labor Standards Act Advisor](#) answers questions about workers and businesses that are subject to the FLSA and its minimum wage and overtime rules.

Penalties

Enforcement of the Act is carried out by Wage and Hour Division investigators stationed throughout the country. A variety of remedies are available to the Department to enforce compliance with the Act's requirements. When investigators encounter violations, they recommend changes in employment practices in order to bring the employer into compliance and request the payment of any back wages due employees. Willful violations may be prosecuted criminally and the violators fined up to \$10,000. A second

conviction may result in imprisonment. Employers who willfully or repeatedly violate the minimum wage or overtime pay requirements are subject to [civil money penalties](#) of up to \$1,000 per violation. When a civil money penalty is assessed, employers have the right, within 15 days of receipt of the notice of such penalty, to file an exception to the determination. When an exception is filed, it is referred to an administrative law judge for a hearing and determination as to the appropriateness of the penalty. If an exception is not filed, the penalty becomes final.

The Secretary of Labor may also bring suit for back pay and an equal amount in liquidated damages and obtain injunctions to restrain persons from violating the Act. Employees may also bring suit, where the Department has not done so, for back pay and liquidated damages, as well as attorney's fees and court costs.

Relation to State, Local and Other Federal Laws

State laws also apply to employment subject to this Act. When both this Act and a state law apply, the law setting the higher standards must be observed.

Child Labor Laws

Some facts about the act:

- A church or business should never hire anyone under 14 other than their own children. Please note that a church may have employees who have children, but this is not the Church's "child." This exception can NEVER be used by a Catholic Church.
- Children 14 and 15 are subject to many hour restrictions as well as not being able to work in a hazardous position.
- Children 16 and 17 may be hired for non-hazardous positions, but the definition is non-hazardous can be tricky. It could be considered hazardous to let a child under 19 get on a ladder.
- Anytime you hire anyone under the age of 19; you must submit proof of age to the US department of labor and obtain a certificate of age. If you do not obtain a certificate of age, you are in violations of the Child labor Act.
- Violations of Child labor laws can range from \$1,000 per violation up to \$10,000 and prison.

Who is Covered?

The child labor provisions of the Fair Labor Standards Act (the Act) are designed to protect the educational opportunities of youths and prohibit their employment in jobs and under conditions detrimental to their health and well-being. These laws apply to churches.

Sixteen is the minimum age for most nonfarm work; however, 14- and 15-year olds may be employed outside of school hours in certain occupations under certain conditions.

Youths may, at any age: deliver newspapers; perform in radio, television, movies, or theatrical productions; work for their parents in their solely owned nonfarm businesses (except in mining, manufacturing, or in any other occupation declared hazardous by the Secretary of Labor); or gather evergreens and make evergreen wreaths.

Basic Provisions/Requirements

The Act's child labor provisions include restrictions on the hours of work and occupations for youths under age 16. These provisions also set forth 17 hazardous occupations orders for jobs declared by the Secretary of Labor to be too dangerous for minors under age 18 to perform. The Act prohibits the shipment of goods in interstate commerce, which were produced in violation of the child labor provisions. It is also a violation of the Act to fire or in any other manner discriminate against an employee for filing a complaint or for participating in a legal proceeding under the Act.

The permissible jobs and hours of work, by age, in nonfarm work are as follows:

- Youths 18 years or older may perform any job for unlimited hours;
- Youths age 16 and 17 may perform any job not declared hazardous by the Secretary of Labor, for unlimited hours;
- Youths age 14 and 15 may work outside school hours in various nonmanufacturing, nonmining, nonhazardous jobs under the following conditions: no more than 3 hours on a school day, 18 hours in a school week, 8 hours on a nonschool day, or 40 hours in a nonschool week. In addition, they may not begin work before 7 a.m. nor work after 7 p.m., except from June 1 through Labor Day, when evening hours are extended until 9 p.m. Youths aged 14 and 15 who are enrolled in an approved Work Experience and Career Exploration Program (WECEP) may be employed for up to 23 hours in school weeks and 3 hours on school days (including during school hours).

Detailed information on the occupations determined to be hazardous by the Secretary is available by contacting the [Wage and Hour Division offices](#).

Department of Labor regulations require employers to keep records of the date of birth of employees under age 19, their daily starting and quitting times, daily and weekly hours worked, and their occupation. Employers may protect themselves from unintentional violation of the child labor provisions by keeping on file an employment or age certificate for each youth employed to show that the youth is the minimum age for the job. Certificates issued under most state laws are acceptable for this purpose.

Assistance Available

More detailed information, including copies of explanatory brochures and regulatory and interpretative materials, may be obtained by contacting the [Wage and Hour Division offices](#).

The [Child Labor Advisor](#) answers questions about workers and businesses that are subject to the FLSA and its child labor rules.

Penalties

Employers are subject to a civil money penalty of up to \$10,000 for each employee employed in violation of the child labor provisions. When a civil money penalty is assessed, employers have the right, within 15 days of receipt of the notice of such penalty, to file an exception to the determination. When an exception is filed, it is referred to an administrative law judge for a hearing and determination as to the appropriateness of the penalty. Either party may appeal the decision of the administrative law judge to the Secretary of Labor. If an exception is not timely filed, the penalty becomes final.

The Act also provides, in the case of a conviction for a willful violation, for a fine of up to \$10,000; or, for a second offense committed after the conviction of such person for a similar offense, for a fine of not more than \$10,000 and imprisonment for up to six months, or both. The Secretary of Labor may also bring suit to obtain injunctions to restrain persons from violating the Act.

Relation to State, Local and Other Federal Laws

Many states have child labor laws. When both this Act and a state law apply, the law setting the higher standards must be observed.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. It also requires that group health benefits be maintained during the leave.

The FMLA is designed to help employees balance their work and family responsibilities by taking reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers, and promotes equal employment opportunity for men and women.

The Family & Medical Leave Act:

- covers only certain employers;
- affects only those employees eligible for the protections of the law;
- involves entitlement to leave;
- maintains health benefits during leave;
- restores an employee's job after leave;
- sets requirements for notice and certification of the need for leave;
- protects employees who request or take leave; and
- includes certain employer record keeping requirements.

If you think that you have someone that may fall under this act, please call the Fiscal Office for details.

Related Laws:

A number of states have also enacted family and medical leave laws, some of which provide greater amounts of leave and benefits than those provided by FMLA, and/or provide benefits to employees who are not eligible for FMLA leave. In those situations where an employee is covered by both Federal and State FMLA laws, the employee is entitled to the greater benefit or more generous rights provided under the different parts of each law. Some employees may also be entitled to protections provided by the Americans with Disabilities Act (ADA) which is administered by the Equal Employment Opportunity Commission (EEOC).

EEOC - The U.S. Equal Employment Opportunity Commission

EEOC - An Overview

What laws does the Equal Employment Opportunity Commission enforce? The Equal Employment Opportunity Commission (EEOC) enforces the following federal laws: Title VII of the Civil Rights Act of 1964 (Title VII), Age Discrimination in Employment Act (ADEA), Equal Pay Act (EPA), and the Americans with Disabilities Act (ADA). These laws prohibit employment discrimination based on race, color, sex, religion, national origin, age, disability or in retaliation for opposing job discrimination, filing a charge or participating in proceedings under the laws. EEOC's mandate is to determine in a fair and objective manner whether the laws it enforces have been violated.

What small businesses are covered?

The laws cover all private employers, state and local government employers, and educational institutions that employ 15 or more individuals, except for ADEA, which covers employers with 20 or more employees. These laws also cover private and public employment agencies, labor organizations, and joint labor management committees controlling apprenticeship and training.

When can employees file charges?

Employees must file their charge with EEOC within 180 days from the date of the alleged discrimination. If the employer is also covered by a state or local employment discrimination law, the time to file a charge with EEOC is extended to 300 days.

How are charges filed with the EEOC?

Any individual who believes that his or her employment rights have been violated because of his or her race, color, sex, religion, national origin, age, disability or because of retaliation may file a charge of discrimination with EEOC. Under statute, EEOC must accept the filing of a charge..EEOC investigators interview individuals alleging employment discrimination to establish whether we have jurisdiction. Investigators explore in detail a potential charging party's description of the alleged violation and the pertinent date(s). This information is assessed to determine the potential merits of the charge. Based upon our assessment, we advise the potential charging party whether we will investigate or immediately dismiss the charge. EEOC will notify the employer within 10 days of accepting a charge. Notification normally includes a copy of the charge briefly identifying (a) the charging party, (b) the bases and issue(s) of the allegation, (c) the date of the alleged violation, and (d) an explanation of the employer's obligation to retain records pertaining to the charge. An invitation to mediate the complaint may also be included in the notification package.

Can a small business resolve a charge without an investigation?

Yes! EEOC has a free mediation program. The program is voluntary at all stages of the process. Neutral mediators provide employers and charging parties the opportunity to reach mutually agreeable solutions, while making efficient use of their time and money. In the event that mediation does not result in a settlement, the charge is referred for investigation. Information disclosed by the parties during the mediation will not be used as a part of EEOC's investigation. Moreover, mediators are bound by confidentiality provisions and may not provide information about the mediation to EEOC investigative staff.

How does EEOC investigate allegations of employment discrimination?

An EEOC investigator asks the employer to respond to the allegations in the charge and provide documentation to substantiate its response. EEOC usually asks for a written answer; however, on-site visits may occur to conduct document reviews and interviews. Although it is not usually necessary, if an employer does not provide the requested information or access, the EEOC may issue a subpoena for access, documents, or testimony. As soon as practical after we receive the position statement and gathering evidence from the employer, EEOC will determine whether to investigate further, propose settlement or dismiss the charge.

What are an individual's rights once the charge has been dismissed?

If EEOC decides that there is insufficient evidence to conclude that a violation exists, the investigator explains the rationale for the decision to the charging party. He or she is given a dismissal notice, which includes the right to file a lawsuit in federal court. The statutes EEOC enforces give a charging party the right to proceed in court within 90 days of receiving their dismissal notice. The laws also permit the charging party to choose to proceed to federal court instead of waiting for the EEOC to complete its investigation. In some cases, EEOC may issue a notice of right to sue upon the charging party's request.

What does the EEOC do if it determines that a violation has occurred?

If EEOC decides that there is reasonable cause to believe that discrimination occurred, the investigator explains the rationale to the employer. This is followed by a written determination and invitation to enter into conciliation discussions. The purpose of these discussions is to eliminate the discrimination and provide relief to the charging party and others, if appropriate, without going to court. Negotiations will continue for a reasonable period until the case is resolved or conciliation fails. Conciliation agreements are ordinarily signed by the charging party, the employer, and the EEOC office director.

Under what circumstances will EEOC pursue a charge in federal court?

If the conciliation efforts fail, EEOC will determine if it will sue a private employer or recommend litigation to the Department of Justice for state and local government

employers. If EEOC decides against litigation, the charging party will be given his or her right to file a lawsuit in federal court.

Resolutions

Need to be completed anytime trustees change or new signatures are needed on bank accounts. Need a resolution naming officers and one for authorizing signatures. (See forms section for sample forms).

Insurance Requirements for new construction

Upon receipt of the following, the Pastor may authorize construction to begin: (1) the construction contract from the Bishop, (2) proof of insurance from the contractor (at least \$1,000,000 liability coverage [\$1,000,000/occurrence with 2,000,000 aggregate], workers compensation coverage, and automobile coverage naming the parish/institution and the diocese as additional insured on all coverage's, and (3) a performance and payment bond from the contractor (on contracts over \$50K).

Hiring Outside Labor-W-9 Issues

- Please remember that any time the Diocese pays stipends, rents, services (including parts and materials), prizes and awards, other income payments, and medical and health care payments, the Diocese must have a completed W-9 before a check can be issued. A 1099 will be issued to anyone who accumulates over \$600 of these types of payments. We obtain W-9's on all amounts because of due diligence requirements by IRS. Due to Federal laws, the Diocese will not issue a check without a W-9. This is because churches can be penalized if the social security number reported on the 1099 is incorrect, unless "due diligence" is exercised – what this means is that according to IRS regulations, 'due diligence' will have been exercised if the church has obtained a W-9. It is recommended that 31 % in backup withholding be withheld unless the person completes a W-9 form.
- Please be aware that checks may not be issued directly to the religious sisters, brothers, or priests. The checks must be issued to their order.
- Form-W-9 (see form section)

Workers Compensation

Please note:

- When an employee is injured, the employer should help the injured employee complete the employer report of illness as soon as possible. If the employee is incapable of completing the report, then the employer should complete it to the best of their ability and report the incident to the AVIZENT (formerly Frank Gates Company) (1-800-274-7925) ASAP. Remember to include the employee's date of birth on this form. Note that in boxes 27, 29 and 30-the information should be your location name, address and telephone number. Please complete these boxes. Please send a copy of this form to the Diocese and the original to

AVIZENT. DO NOT SEND A COPY TO THE OFFICE OF WORKERS COMPENSATION-AVIZENT will do this for you.

- Please do not instruct the hospital or physician to send the bills to the Diocese. Bills are to be sent and approved by AVIZENT.
- Please note that there are no DIOCESAN APPROVED DOCTORS OR FACILITIES. If we direct an employee to a doctor or facility, then we may lose certain rights. The employee may choose their doctor or hospital (one doctor should be chosen-no shopping for doctors). If an employee wishes to change doctors, they must contact the AVIZENT for approval. Please make this clear to them.

Workers Compensation Worksheet

At the end of each year, the Fiscal Office has requested that the schools and parishes provide all payroll and any 1099 information. Also, a copy of all 941 's should be submitted.

For the parishes, they will receive a listing from the Fiscal Office with December Books & W-2's. Please identify the job that each person does and return this list along with a copy of your 941 's to the Fiscal Office.

For the schools please complete the Workers Compensation worksheet. This form should be typed & returned to Fiscal. Also, please send a copy of all 941 reports.

Completion of this form will assure that the correct numbers are used for your workers compensation premium calculation. If these forms are not completed timely, the fiscal office will guess as best as we can and complete the form for you. However, please remember that your premium will be set for the next year. The sum of these forms should agree with the total salaries shown on the schedule. Please feel free to call if you have any questions.

Diocesan Record Retention Guidelines

Records

Retention Periods

| | |
|--|-----------------------------|
| Audit reports | Permanent |
| Bank Deposit Slips | 7 years |
| Bank statements | 7 years |
| Cancelled Checks | 7 years |
| Certificates of INS. | 4 years |
| Contracts and leases | Permanent |
| Daily cash receipts | 7 years |
| Depreciation schedules | Life of assets plus 3 years |
| Employee records | Permanent |
| Employee time cards | 3 years |
| Entertainment records | 6 years |
| Expense reports | 6 years |
| Financial Statements | Permanent |
| General ledgers | Permanent |
| General Journals | Permanent |
| Insurance claims | 5 years after settlement |
| Insurance policies | Permanent |
| Inventory records | 3 years |
| Loss reports | 5 years |
| Minutes of meetings | Permanent |
| OSHA records | 5 years |
| Paid vendor invoices | 7 years |
| Real Estate Records | Permanent |
| Tax returns and supporting documentation | Permanent |
| Tax and legal correspondence | Permanent |

SECTION II

CHART OF ACCOUNTS

CHART OF ACCOUNTS

ASSETS (1000-1999)

| | |
|------|--------------------------------|
| 1010 | CASH IN BANK |
| 1011 | CASH IN BANK – MISSION |
| 1012 | CASH IN BANK – MASS INTENTIONS |
| 1120 | PETTY CASH FUND |
| 1130 | CERTIFICATES OF DEPOSIT |
| 1140 | PASSBOOK SAVINGS |
| 1150 | INVESTMENTS |
| 1250 | PREPAID EXPENSES |
| 1300 | LOANS RECEIVABLE |
| 1421 | ACCOUNTS RECEIVABLE |
| 1520 | LAND |
| 1530 | BUILDINGS AND IMPROVEMENTS |
| 1540 | CONSTRUCTION IN PROGRESS |
| 1550 | FURNISHINGS & EQUIPMENT |
| 1560 | VEHICLES |
| 1570 | CEMETERIES & MAUSOLEUMS |

REVENUES

| | |
|------|--------------------------|
| 4010 | OFFERTORY – PARISH |
| 4011 | OFFERTORY – MISSION |
| 4020 | OFFERTORY – HOLY DAYS |
| 4030 | BUILDING FUND |
| 4031 | MEMORIALS |
| 4070 | GAIN (LOSS) SALE OF INV |
| 4090 | INTEREST/DIVIDEND INCOME |
| 4124 | CEMETERY INCOME |
| 4125 | CEMETERY EXPENSE |
| 4170 | RENTAL/LEASE INCOME |
| 4201 | CONTRIBUTIONS/DONATIONS |

EXPENDITURES

| | |
|------|-----------------------------|
| 5110 | SALARIES – CLERGY |
| 5111 | SALARIES – RELIGIOUS |
| 5112 | SALARIES – DEACON |
| 5120 | SALARIES – LAY |
| 5140 | SALARIES – SUB CLERGY |
| 5213 | FICA – PARISH SHARE |
| 5230 | WORKERS COMPENSATION |
| 5235 | LIFE INSURANCE |
| 5250 | HOSP INS – CLERGY |
| 5251 | HOSP INS – RELIGIOUS |
| 5252 | HOSP INS – LAY |
| 5260 | RETIREMENT – CLERGY |
| 5261 | RETIREMENT – RELIGIOUS |
| 5270 | RETIREMENT – LAY |
| 5291 | CLERGY WELFARE |
| 5320 | TRAVEL & TRANSPORTATION |
| 5322 | BUSINESS ALLOWANCE – CLERGY |
| 5330 | POSTAGE |
| 5346 | PUBLIC RELATIONS |
| 5350 | GENERAL INSURANCE |
| 5360 | UTILITIES |
| 5370 | TELEPHONE |
| 5380 | REPAIR & MAINTENANCE |

LIABILITIES/EQUITY

| | |
|------|---------------------------|
| 2101 | LOANS PAYABLE |
| 2221 | FICA W/H |
| 2222 | FED W/H |
| 2223 | RETIREMENT W/H – METLIFE |
| 2224 | MEDICARE W/H |
| 2230 | STATE W/H |
| 2231 | HOSPITAL INS W/H |
| 2232 | OTHER W/H |
| 2233 | RETIREMENT W/H – 403B |
| 2234 | LIFE & DISABILITY INS |
| 2240 | ACCOUNTS PAYABLE |
| 2260 | CUSTODIAL ACCOUNTS |
| 2500 | MASS INTENTIONS |
| 27XX | NATIONAL COLLECTIONS |
| 28XX | DIOCESAN COLLECTIONS |
| 3100 | FUND BALANCE |
| 4381 | FESTIVAL INCOME |
| 4382 | FESTIVAL EXPENSE |
| 4390 | BEQUESTS |
| 4600 | SCHOOL OF RELIGION (CCD) |
| 4610 | YOUTH INCOME |
| 4620 | CHARITY INCOME |
| 4630 | ALTAR SERVERS |
| 4640 | ALTAR SOCIETY |
| 4650 | CHOIR INCOME |
| 4675 | OTHER INCOME |
| 4685 | HURRICANE RELIEF INCOME |
| 49XX | SUBSIDIES |
| 5390 | RENTAL EXPENSE |
| 5420 | OFFICE SUP/EXPENSES |
| 5422 | LEGAL & PROFESSIONAL FEES |
| 5430 | RESIDENCE SUPPLIES |
| 5435 | CHURCH SUPPLIES |
| 5450 | BOOKS/PERIOD/SUBSCRIP |
| 5460 | DUES & MEMBERSHIPS |
| 5470 | CONFERENCES |
| 5480 | CIVIL TAXES |
| 5481 | RELIGIOUS EDUCATION |
| 5482 | YOUTH MINISTRY |
| 5483 | EVANGELIZATION |
| 5484 | RELIGIOUS ED ADULT |
| 5485 | LITURGY EXPENSE |
| 5640 | BSA QUOTA (EXCESS) |
| 5650 | PAROCHIAL TITHE |
| 5670 | DIOCESAN QUOTA (EXCESS) |
| 5705 | INTEREST EXPENSE |
| 5720 | SUBSIDY – SCHOOL |
| 5730 | SUBSIDY – CHAPLAIN |
| 5740 | CHARITIES |
| 6001 | CAPITAL EXPENDITURES |
| 6002 | HURRICANE EXPENDITURES |

THE SOCIETY OF THE ROMAN CATHOLIC CHURCH OF THE DIOCESE OF LAKE CHARLES

(Parishes)

THE FOLLOWING IS A DESCRIPTION OF EACH GENERAL LEDGER ACCOUNT USAGE AND CONTENT AND SHOULD BE USED TO INSURE A UNIFORM AND CONSISTENT CLASSIFICATION OF TRANSACTIONS IN THE GENERAL LEDGER.

ASSETS (1000 -- 1999)

1010 CASH IN BANK

The balance of cash held by the bank for the benefit of the institution. This is the account from which checks are written and daily deposits made.

1012 CASH IN BANK --MASS INTENTIONS

The balance of cash held by the bank for the benefit of maintaining a control of mass intention funds.

1120 PETTY CASH

The balance of all imprest or petty cash accounts usually for the benefit of various departments. A sum set aside to pay small bills that are not convenient to pay by check.

1130 CERTIFICATES OF DEPOSIT

The balance of money held by banks in certificates of deposit for the benefit of the parish in the form of interest bearing deposits subject to withdrawal restrictions prior to maturity.

1140 PASSBOOK SAVINGS

The balance of regular savings subject to restrictions.

1150 INVESTMENTS

The balance of money invested in other debt or equity securities from which the parish realizes income. An example would be a US Treasury obligation - Mutual Funds - Merrill Lynch-Ed Jones - Fidelity investment.

1250 PREPAID EXPENSES

The payments for items such as insurance and tuition prior to the date due.

1300 LOANS RECEIVABLE

The loans to others, usually interest bearing.

1421 ACCOUNTS RECEIVABLE

The amounts owed to the parish for various services.

1520 LAND

The acquisition value of land owned by the parish. If land is purchased, this account includes the purchase price and other costs, such as legal fees, and filing and excavation costs which are incurred to put the land in condition for its intended use. If land is donated, the account reflects its appraised value at the time of acquisition.

1530 BUILDINGS AND IMPROVEMENTS

The acquisition value of permanent structures owned by the parish. If buildings are purchased or constructed, the account includes the purchase or contract price of all buildings and fixtures attached to and forming a permanent part of such buildings. If buildings are acquired by gift, the account reflects their appraised value at the time of acquisition. CHECKS WRITTEN FOR THESE ITEMS WILL BE FIRST CODED TO THE EXPENSE ACCOUNT NUMBER (6001) AND TRANSFERRED TO THIS ACCOUNT AT THE CLOSE OF THE FISCAL PERIOD.

1540 CONSTRUCTION IN PROGRESS

The buildings or improvements which are still uncompleted at the close of a fiscal year or at any specific point in time. Upon completion this account is to be "closed out" to (1530).

1550 FURNISHINGS & EQUIPMENT

The cost of furniture and equipment purchased or the fair market value at the date of the gift for items donated. Tangible property that has a life of at least two or more years and used in the operation of the parish. Examples are office furniture and machines, religious articles of value. CHECKS WRITTEN FOR THESE ITEMS WILL BE FIRST CODED TO THE EXPENSE ACCOUNT NUMBER (6001) AND TRANSFERRED TO THIS ACCOUNT AT THE CLOSE OF THE FISCAL YEAR.

1560 VEHICLES

The cost of parish--owned automobiles or machinery such as tractors, backhoes, lawnmowers, etc. used in the operation of the parish and of considerable value. CHECKS WRITTEN FOR THESE ITEMS WILL BE FIRST CODED TO THE EXPENSE ACCOUNT NUMBER (6001) AND TRANSFERRED TO THIS ACCOUNT AT THE CLOSE OF THE FISCAL PERIOD.

1570 CEMETERIES & MAUSOLEUMS

The cost of cemetery and mausoleums purchased or the fair market value at the date of gift for items donated.

1580 SPECIAL NOTE (DONATED PROPERTY AND EQUIPMENT)

It is not unusual for a parish to receive certain gifts of real or personal property other than cash. When such gifts are received they represent a financial "transaction" to the parish and should be recorded both in the proper income account and the corresponding asset account. The value to be used should be the value of the property at the date of the gift. The diocesan assessment is not applicable until the property or equipment is converted to cash --that is, either sold, transferred, etc. However, at that time the entire proceeds are assessable.

2000 -- 2999 LIABILITIES

2101 LOANS PAYABLE

Liability for notes and loans outstanding to banks and others covering borrowing for operations or capital expenditures. Borrowing from the Diocese at interest should also be classified here. Separate accounts should be maintained for each note which will be required by the Diocesan Office on an annual basis.

NOTE: EMPLOYEES' TAXES WITHHELD AND OTHER LIABILITIES. INCLUDES PAYROLL AND OTHER AMOUNTS DEDUCTED FROM EMPLOYEE SALARIES AND ANY OTHER MISCELLANEOUS LIABILITIES NOT CLASSIFIED ELSEWHERE. SEPARATE ACCOUNTS ARE TO BE MAINTAINED FOR EACH CLASSIFICATION. THESE ACCOUNTS SHOULD BE CLEARED WITH THE APPROPRIATE REMITTANCES.

2221 A/C PAYABLE -- F.I.C.A. WITHHOLDING

The amount withheld from payroll checks for social security taxes and matching amounts accrued for the employer share none of which has been remitted.

2222 A/C PAYABLE -- FEDERAL INCOME TAX WITHHELD

The amount withheld from payroll checks for federal income taxes that have not been remitted.

2223 A/C PAYABLE -- RETIREMENT WITHHOLDING

The amount withheld from payroll checks for voluntary contribution the Diocesan retirement plan that have not been remitted.

2224 A/C PAYABLE -- MEDICARE WITHHOLDING

The amount withheld from payroll checks for Medicare taxes and matching amounts accrued for the employer share none of which has been remitted.

2230 A/C PAYABLE -- STATE INCOME TAX WITHHOLDING

The amount withheld from payroll checks for Louisiana state income taxes that have not been paid.

2231 A/C PAYABLE -- HOSPITAL INSURANCE PREMIUM WITHHOLDING

The amount withheld from payroll checks for dependent hospital insurance premiums that have not been paid.

2232 A/C PAYABLE -- OTHER

The amount withheld from payroll checks for other insurance premiums such as life, cancer and similar allowable insurance deductions, garnishments that have not been remitted.

2240 A/C PAYABLE -- GENERAL

The amount owed by the parish for entities to various trade vendors for services or supplies which have not been paid. Some of these accounts are also "custodial accounts".

2260 CUSTODIAL ACCOUNTS

Monies in custody of the Parish for the benefit of other various entities. This can be various checking accounts with the parishes Tax ID number, but are for the benefit of other organizations(such as CCD, youth groups,etc.)

2260.010 SPECIAL MISSIONS

Advent and Lenten missions collected by the parish and remitted directly to the mission leader or organization.

2500 A/C PAYABLE - MASS INTENTIONS

The amounts received for mass intentions which have not been satisfied. (THIS ACCOUNT MUST NOT EXCEED THE AMOUNT OF \$1080 FOR EACH PRIEST ASSIGNED TO THE PARISH.) Any amount in excess of this amount is to be remitted to the Diocese for distribution to areas needing intention. See Appendix J of the Diocesan Policy And Guidelines.

3000 -- 3999 FUND BALANCE

3100 FUND BALANCE

The account equivalent to the excess of the assets over the liabilities of each fund group and which is available for the fund group's specific purpose. Separate accounts should be maintained for each fund balance.

4000 -- 4999 RECEIPTS

ALL REVENUE ACCOUNTS BEGIN WITH A 4XXX. THE FOLLOWING IS A LIST OF UNIFORM DESCRIPTIONS FOR REVENUE ACCOUNTS. THE FIRST THREE DIGITS REPRESENT THE GENERAL CLASSIFICATION OF REVENUE. THE LAST DIGIT CAN BE USED TO SUB-CLASSIFY THE REVENUE. ALL OF THE FOLLOWING ACCOUNTS ARE ASSESSABLE..

4010 COLLECTIONS -- OFFERTORY -- PARISH SUPPORT

The ordinary collections for the support of the parish both by envelope and cash, taken up at the parish masses. This should also include envelopes that are received in the mail and any other contributions which are identifiable as donations, such as monthly, quarterly, semi--annual or annual donations made to the parish.

4011 COLLECTIONS -- OFFERTORY -- MISSION SUPPORT

The ordinary collections for the support of the mission both by envelope and cash, taken up at the mission masses. This should also include envelopes that are received in the mail and any other contributions which are identifiable as donation, such as monthly, quarterly, semi--annual or annual donations made to the mission.

4020 COLLECTIONS HOLYDAY OFFERTORY

The ordinary collections for the support of the parish or mission both by envelope and cash, taken up at the parish or mission masses. This should also include envelopes that are received in the mail and any other contributions which are identifiable as donations such as monthly, quarterly, semi--annual or annual donations made to the parish or mission.

4030 COLLECTION BUILDING FUNDS/SPECIAL PURPOSE

Income received from collections/appeals designated for specific restoration, repair or renovation projects, new construction, major additions or for a specific purpose such as the purchase of a new altar, lectern, P A system, piano, organ or some other specific building project or item. Upon request, the Bishop may determine assessment/non-assessment. Generally, assessments may be waived for a one year period (after prior approval for the waiver from the Bishop, substantiated by a letter). Please note, however, that the assessment must still be remitted to the Diocese. At the end of the waiver period, the assessment paid will be returned to the parish as a subsidy from the Diocese.

4031 MEMORIALS

A donation received and restricted for a specific memorial purpose, i.e. altar, vestments, etc. Upon request, substantial donations may be reviewed by the Diocesan Finance Council with assessment/non--assessment determination by the Bishop.

4070 GAIN (LOSS) ON SALE OF SECURITIES

Net income received from the sale of stock, bonds, etc. Net income is defined as the sale price less any selling expenses, commissions, fees and cost (purchase price) of the original stock.

4070 GAIN (LOSS) ON SALE OF REAL ESTATE

Net income received from the sale of land, buildings, and other real property. Net Income is defined as the sale price less any selling expenses, commissions, fees, and the original cost of the property.

4090 INTEREST/DIVIDEND EARNED

Income realized in the form of interest & dividends from the investment of funds in savings account, certificates of deposit, mutual funds, Merrill Lynch, Ed Jones, Fidelity investment, etc (UNREALIZED GAINS & LOSSES ARE EXCLUDED AND NOT ASSESSABLE UNTIL REALIZED, THAT IS, EITHER SOLD, TRANSFERRED, ETC.)

4124 CEMETERY INCOME

Income received from the sale of cemetery plots & mausoleums.

4125 CEMETERY EXPENSE

Expenses to maintain the cemetery such as grass cutting, utilities, ordinary maintenance and required reserve amounts. This amount will subtract from 4124 Cemetery Income.

4170 RENTAL INCOME (LEASES)

Income received from the rental of parish or mission property by outside organizations or individuals. Outside organizations or individuals are defined as non--parish or non--parishioner

sponsored events of which the parish or mission is not the beneficiary. Only direct expenses should be deducted.

4170 RENTAL INCOME (REAL ESTATE)

Income from revenue producing assets such as timber, farming, pasture rental, land, right of ways, etc.

4170 OIL & GAS LEASES & ROYALTIES

Income from leases of church property for oil and gas exploration/production including bonus payments. Excludes reimbursement for property damage and restoration.

4201 CONTRIBUTIONS--DONATIONS

Contribution from parishioners and other persons not properly classified as collections. This includes donations of a general nature in which there is no specific intent on the part of the donor. Contributions designated and given for a specific purpose, i.e. purchase of altar, computer are also included in this category.

4381 FESTIVAL/FAIR/BINGO & OTHER BENEFITS INCOME

Income from these and similar types of fund raising events of which the parish, mission or any of its programs are the beneficiary. Fund raising activities for the direct benefit of an elementary or high school are excluded and non--assessable.; No credit will be given for net losses.

4382 FESTIVAL/FAIR/BINGO & OTHER BENEFITS EXPENSES

Expenses are recorded separately and will subtract from 4381 income. Indirect cost such as utilities, cleaners, etc. may not be deducted. Change for cash is to be reimbursed immediately after the benefit because this is reimbursable and not an expense—this is not to be coded in this account. You may code this as petty cash (remember this is a temporary entry). Please call the Fiscal office if you are unsure about the procedure.

4390 BEQUESTS

Any donations from estate settlement of a non recurring nature given to the parish or mission through wills or other designations. Upon request, substantial donations may be reviewed by the Diocesan Finance Council with assessment/non--assessment determined by the Bishop.

THIS CONCLUDES THE ASSESSABLE ACCOUNT DESIGNATIONS

THE FOLLOWING ACCOUNTS ARE NON-ASSESSABLE

4500 MASSES SAID

Income received for masses said (satisfied).

46XX OTHER NON-ASSESSABLE RECEIPTS

These are collections for the benefit of other organizations within the Parish.

- 4600 School of Religion (PREP, CCD)
- 4610 Youth Income (CYO)
- 4620 Charity Income (St. Vincent de Paul, etc.)
- 4630 Altar Servers
- 4640 Altar Society
- 4650 Choir Income

4670 GAIN/LOSS ON THE SALE OF OTHER DEPRECIABLE ASSETS

Net income received from the sale of other depreciable assets, such as furniture, automobiles, appliances, etc. Net income is defined as the sale price less selling expenses, commissions, fees, and the original cost of the property.

4675 OTHER INCOME

Donations specifically earmarked for candles, flowers, missals, and bulletins. These are small donations specifically to defray the cost of these items.

NOTE: THE FINANCIAL ACTIVITIES OF CATHOLIC SCHOOLS SHOULD BE KEPT SEPARATE FROM PARISH ACTIVITIES. RECEIPTS BY THE PARISH EXPLICITLY ON BEHALF OF THE SCHOOL ARE AGAINST BOTH DIOCESAN POLICY AND FEDERAL & STATE LAW.

47XX NATIONAL COLLECTIONS

Proceeds of these collections are recorded upon receipt and forwarded to the Fiscal Office preferably the week following the collection.

- 4711 Campaign For Human Development
- 4712 Catholic Communications Campaign
- 4713 Catholic Relief Services
- 4714 Catholic University
- 4715 Holy Land
- 4716 Latin America
- 4717 Mission Sunday
- 4718 Church in Eastern Europe

- 4719 Negro & Indian Missions (Home Mission)
- 4720 Peters Pence (Holy Father)
- 4721 Catholic Home Mission Appeal (CHMA)
- 4722 Catholic Relief Special *to be announced and specified.*
- 4723 Rice Bowl
- 4724 Retirement Fund For Religious (DIOCESAN COLLECTION-SEE 4819)

48XX DIOCESAN COLLECTIONS

Proceeds of these collections are recorded upon receipt and forwarded to the Fiscal office preferably the week following the collection.

- 4811 Bishop's Services Appeal
- 4812 Christmas Charities
- 4813 First Friday Offerings
- 4815 Mission Cooperation
- 4816 Religious Education
- 4817 Seminary
- 4818 Retreat Center
- 4819 Retirement Fund for Religious

49XX SUBSIDIES

Funds received from sources in the form of subsidy.

- 4901 N.I.C. Grant Funds

4902 A.B.C.M. Grant Funds

4903 Needy Parish Funds

4904 C.C.E.S Grant Funds

4910 Other Funds

THIS CONCLUDES THE NON-ASSESSABLE ACCOUNT DESIGNATIONS

5000 -- 5999 (EXPENDITURES)

ALL EXPENDITURES BEGIN WITH 5XXX. THE FIRST THREE DIGITS DESIGNATE THE OBJECT OF EXPENDITURE. THE LAST DIGIT CAN BE USED TO BREAKDOWN AN OBJECT OF EXPENDITURE INTO SMALLER CATEGORIES. GENERALLY, AMOUNTS SHOULD NEVER BE

CREDITED TO AN EXPENSE ACCOUNT EXCEPT FOR VOIDED CHECKS AND VENDOR REFUNDS.

51XX SALARIES & WAGES

The gross amount paid to persons who are employed in positions of a permanent or temporary nature, including temporary personnel substituting for regular employees.

5110 Salaries--Clergy

5111 Salaries--Religious

5112 Salaries--Deacon

5120 Salaries--Lay

5140 Salaries--Substitute Clergy

5213 PAYROLL TAXES -- EMPLOYER SHARE

Also termed Social Security and Medicare it represents the employer's share of the periodic payment (a percentage of qualified wages) made to the Internal Revenue Service for this insurance benefit. It does not include the employee's share withheld from wages which should be charged to account 2221 A/C payable FICA and account 2224 A/C payable Medicare.

5230 WORKERS COMPENSATION

Premium paid for workers compensation insurance provided for employees.

5235 LIFE INSURANCE

Premium paid for seminary burse insurance as well as life insurance provided for employees.

5250 HOSPITAL INSURANCE--CLERGY

5251 HOSPITAL INSURANCE--RELIGIOUS

5252 HOSPITAL INSURANCE--LAY

Includes only the amounts which represent a true expense to the parish; not amounts withheld from payroll checks.

5260 RETIREMENT--CLERGY

5261 RETIREMENT--RELIGIOUS

5270 RETIREMENT LAY

Insured or trusted plans for the benefit of employee retirement or for their survivors. Many times the insured's plans are interrelated or billed to employers at combined rates. Detailed accounts will depend upon the needs of each parish. These accounts should include only the employer's share of each payment and account numbers must be secured From the Fiscal Office.

5291 CLERGY WELFARE

A sum paid to the Diocese on an annual basis to provide clergy support.

5320 TRAVEL & TRANSPORTATION

Costs for transportation, meals, hotel, and other expenses associated with traveling for the parish. Payments for per diem in lieu of reimbursements for subsistence (room & board) are also charged here.

5330 POSTAGE

Amounts paid for mailing (stamps and other mailing costs, including postage meter rental), parcel post, trucking and other delivery costs. This includes mailroom supplies unless the mailroom is set up as a separate activity, in which case supplies would be included in *supplies, materials & expenses*.

5346 PUBLIC RELATIONS

This would include entertainment of parish volunteers, employees, etc., such as a dinner for the parish choir.

5350 GENERAL INSURANCE

Expenditures for all types of insurance coverage, such as property, liability, and fidelity bond premiums, as well as the cost of judgments. Personal insurance for group health is *not* charged here.

5360 UTILITIES

Expenditures for services usually provided by public utilities, such as water, sewerage, electricity and gas as well as cable TV. Costs for telephone are not charged here but are recorded under 5370 Telephone. A detail account may be designated by using the last digit of this account number.

5370 TELEPHONE

Expenditures for all types of telephone services, including installation.

5380 REPAIR & MAINTENANCE

Expenditures for repairs and maintenance services not provided directly by parish personnel. This included contract and agreements covering upkeep of grounds, buildings, equipment, renovating and remodeling.

5390 RENTALS

Expenditures for the lease or rental of land, buildings, and equipment for the temporary or long--range use of the parish. This includes vehicle rental, lease of data processing equipment, lease--purchasing arrangements and similar rental agreements.

54XX SUPPLIES & MATERIALS

Expenditures for items which are actually or constructively consumed or used in the operation of a parish, including freight and cartage on them. A supply item s any article or material which meets any one or more of the following conditions: (1) it is consumed in use; (2) it loses its original shape or appearance with use; (3) it is expendable; that is, if the article is damaged or some of its parts are lost or worn out, it is usually more feasible to replace it with an entirely new unit rather than repair it, (4) it is an expensive item, having characteristics of equipment whose small unit cost make it inadvisable to capitalize the item, or (5) it loses its identity.

5420 OFFICE SUPPLIES & EXPENSES

Ordinary operational expenses for day to day maintenance of office procedures, purchase of equipment is not coded to this account. It is recorded in account 6001 Capital Improvement.

5421 LEGAL & PROFESSIONAL FEES

Expenses which are incurred for fees such as accounting or legal matters excluding those pertaining to the purchase of property.

5430 RESIDENTIAL SUPPLIES

Expenditures incurred in daily maintenance of the clergy residence.

5435 CHURCH SUPPLIES

Expenditures incurred in the ordinary operation of the church, including candles, hosts, missalettes and hymnals.

5450 BOOKS--PERIODICALS--SUBSCRIPTIONS

Expenditures for books, periodicals and newspapers available for general use by the Parish.

5460 DUES & MEMBERSHIP

Expenditures by the parish for dues and memberships on behalf of the parish or specific individuals.

5470 CONFERENCES

Amounts paid for conducting or attendance at meetings, seminars, retreats, conference workshops, committees, etc.

5480 CIVIL TAXES

Expenditures levied by a governmental unit for the purpose of financing services performed for the common benefit. The term includes, permits and special assessments. It does not include payroll taxes; only penalties levied by the I.R.S.

5481 RELIGIOUS EDUCATION--GENERAL

All expenditures incurred in the conducting of religious education (CCD) programs. It does *not* include salaries or payroll taxes.

5482 YOUTH MINISTRY

All expenditures incurred in the conduction of youth programs. It does *not* include salaries or payroll taxes.

5483 EVANGELIZATION

All expenditures incurred in the course of conducting programs of evangelization .

5484 RELIGIOUS EDUCATION --ADULT

All expenditures incurred in the course of adult religious educating programs including programs for the aged.

5485 LITURGY EXPENSE

Those expenditures incurred in the preparation of atmosphere for good celebration.

5640 REMITTANCE--B.S.A. COLLECTION

Proceeds of the Bishop's Services Appeal are transmitted to the Diocese through this account.

5640 REMITTANCE--DIOCESAN TITHE

Calculated tithe at 11% of assessable amounts are transmitted to the Diocese through this account.

5660 REMITTANCE--NATIONAL COLLECTIONS

Proceeds of all national collections are transmitted to the Diocese through this account.

5670 REMITTANCE--DIOCESAN COLLECTIONS

Proceeds of all diocesan collections are transmitted to the Diocese through this account.

57XX SUBSIDIES

Payments made to activities or organizations within or outside the parish organization without the intent that any repayment is to be made. Detail accounts will depend upon the desire of each parish.

5720 SUBSIDY--SCHOOL

Amounts paid by the parish to support a parochial or inter parochial school. Could be payments made direct and on behalf of the school vendor such as utility or insurance charges.

5730 SUBSIDY--CHAPLAIN

Amounts paid by the parish to support the activities of a chaplain such as a Hospital or prison chaplain.

5740 CHARITIES

Amounts paid to assist someone or something because of need.

6001 CAPITAL EXPENDITURES

Items purchased with a life expectancy of at least three (3) years or longer. This includes purchase of any new equipment for the office, church or rectory, including new furniture. Replacement of worn-out or damaged items are not included here but would be shown as a repair and maintenance expenditure. i.e. roofing or carpeting.

SECTION III

FORMS

INTERNAL CONTROLS..... SECTION A

1. Cash Count Sheet
2. Deposit Listing
3. Deposit Listing (2 signatures)
4. Check Request
5. Expense Form
6. Journal Entry
7. Bank Reconciliation
8. Registration/event form
9. BSA Postage Recap

HUMAN RESOURCE/PAYROLL RELATED FORMS..... SECTION B

1. Form W-4 (for withholding allowances - Federal)
2. Form L-4 (for withholding allowances - State)
3. Form W-9 (for Tax-ID number, informational memo is attached)
4. Form 1-9 (for all new hires-federal requirement)
5. Application for employment
6. Volunteer Profile
7. Criminal Record Check, Employees and Volunteers
8. LA OWCA Second injury Board questionnaire
9. Weekly Timesheet
10. Annual Timesheet
11. Year-end payroll Checklist
12. Checklist for use in Preparing Tax Returns for Priest
13. Priest Business Reimbursement Form
14. Worksheet to compute workers compensation

HEALTH INSURANCE FORMS..... SECTION C

1. Continuing Coverage (with informational memo)
2. Continuation of Health Benefits Form
3. Application for coverage (waiver on front of form)
4. Continuation of Coverage under Cobra or State Group
5. Coverage Cancellation Form
6. CONEXIS Form

7. Claim Form
8. Cafeteria Benefit Plan (to use when an employee elects dependent coverage)
9. Paid Prescription Reimbursement Form
10. Authorized Delegate Form
11. Dependent Certification
12. Checklist for Continuation of Coverage

RETIREMENT SECTION D

1. Retirement Information Sheet
2. DOLC Money Accumulation Plan (form when an employee leaves and has Brighthouse (MetLife, Travelers) or for when an employee want to withdraw from the Brighthouse (MetLife, Travelers) plan)
3. Participant Information Sheet- Brighthouse (MetLife, Travelers)
4. Salary Reduction Agreement
5. Retirement Contribution Report- Brighthouse (MetLife, Travelers)
6. Retirement Contribution Report- Fidelity
7. Benefit Decline Form
8. Account Verification Form for Retirement

RESOLUTION/PROMISSORY NOTE..... SECTION E

1. Sample Resolution
2. Sample Promissory Note

PROPERTY INSURANCE SECTION F

1. Consolidated Insurance program
2. General Liability Claim Information
3. Property Claim Information
4. Workers Compensation Claim Form
5. Auto Accident Form
6. Special Events Form
7. Student Accident Form
8. Volunteer Accident Form

SALES TAX SECTION G

1. State of Louisiana Department of Revenue - Revenue Ruling
2. Application for Exemption from Collection of Louisiana Sales Tax at Certain Fundraising Activities
3. Raffle Guidelines
4. Application for License Exemption to Conduct Charitable Gaming
5. Raffle Accountability

RESERVED SECTIONS H-L

SUBSECTION A

INTERNAL CONTROLS

1. Cash Count Sheet
2. Deposit Listing (2 signatures)
3. Check Request
4. Expense Form
5. Journal Entry
6. Bank Reconciliation
7. Registration/Event Form
8. BSA Postage Recap

COLLECTION COUNT SHEET

DATE: _____

DESCRIPTION OF EVENT: _____

TOTAL CURRENCY: \$_____

TOTAL COIN: \$_____

TOTAL CHECKS: \$_____

TOTAL ENVELOPES: \$_____

GRAND TOTAL: \$_____

PLEASE SIGN BELOW:

SIGNATURE

SIGNATURE

DEPOSIT DETAIL

DATE: _____

CASH ACCT NO: _____

[illegible]

Pastor Signature

Bookkeeper Signature

REQUEST FOR CHECK

TO: _____

DATE: _____

TOTAL AMOUNT: _____

VENDOR NO: _____

| A/C NO. | DEPT | LOC | DESCRIPTION & DETAIL | AMOUNT |
|---------|------|-----|----------------------|--------|
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DELIVER CHECK TO: _____

SIGNED: _____

PAYMENT DATE: _____

APPROVED: _____

Expense Reimbursement Report

Name

Department

Period Ending

Itemize All Reimbursable Expenses in Appropriate Blanks & Attach Supporting Documents -- Be Sure To Total Each Column & Recap Charges

| | | Conference Expenses | | | | Automobile Expenses | | | |
|-----------------------|-----------------|----------------------------|------------|------|-------|----------------------------|-------------|--------|-------|
| Day | Activity | Lodging | Air Travel | Taxi | Meals | Mileage | Description | Amount | Total |
| | | | | | | | | | |
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| | | | | | | | | | |
| Category Total | | | | | | | @ \$0.48 | | |

| OTHER EXPENSES | | |
|-----------------------|-------------|--------|
| Account Code | Description | Amount |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| Total Other Expenses: | | |

Total Other Expenses

| | |
|-----------------------------------|--|
| Grand Total Expenses | |
| Less: Advance (enter as negative) | |

Net Expenses

Signature _____

Approval

DIOCESE OF LAKE CHARLES JOURNAL ENTRY FORM

TODAY'S DATE: _____

PARISH: _____

PERIOD ENDED: _____

CITY: _____

PARISH NO: _____

[illegible]

PARISH NAME: _____ PARISH NO: _____
 CITY: _____ ACCT NO: _____ MONTH: _____

CASH SUMMARY

CASH BALANCE - End of the Previous Month (Per General Ledger) \$ _____

ADD - Deposits Made This Month \$ _____

TOTAL TO ACCOUNT FOR: \$ _____

LESS - Checks Written This Month \$ _____

Paycor \$ _____

Non-Check Withdrawals (Drafts) \$ _____

TOTAL DISBURSEMENTS: \$ _____

CASH BALANCE - End of Current Month (Per General Ledger) \$ _____

BANK RECONCILIATION

ENDING BALANCE (As it Appears on Bank Statement) \$ _____

ADD - Deposits Not Appearing on Bank Statement \$ _____

TOTAL: \$ _____

LESS - Checks Outstanding

Check Amount

Check Amount

Check Amount

TOTAL CHECKS OUTSTANDING: \$ _____

RECONCILED BALANCE: \$ _____

SUBSECTION B

HUMAN RESOURCES/PAYROLL

1. Form W-4 and instructions (for federal withholding)
2. Form L-4 (for state withholding)
3. Form W-9 (for vendors)
4. Form I-9 (all new hires – federal requirement)
5. Application for Employment
6. Volunteer Profile
7. Criminal Record Check (employees and volunteers)
8. LA OWCA Second Injury Board Questionnaire
9. Annual Timesheet
10. Year-End 1099 Checklist
11. Checklist for Use in Preparing Tax Returns for Priests
12. Priest Business Reimbursement Form

Employee's Withholding Certificate

OMB No. 1545-0074

- ▶ **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.**

2022

| | | | |
|---|--|-----------|--|
| 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 2022 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) |

General Instructions

Section references are to the Internal Revenue Code.

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 2022 if you meet both of the following conditions: you had no federal income tax liability in 2021 **and** you expect to have no federal income tax liability in 2022. You had no federal income tax liability in 2021 if (1) your total tax on line 24 on your 2021 Form 1040 or 1040-SR is zero (or less than the sum of lines 27a, 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 2022 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, 2023.

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. 501, Dependents, Standard Deduction, and Filing Information. You can also include **other tax credits** for which you are eligible in this step, such as the foreign tax credit and the education tax credits. 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 2022 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.

| | |
|---|--|
| <p>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</p> <p>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.</p> <p>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</p> <p>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</p> <p>c Add the amounts from lines 2a and 2b and enter the result on line 2c</p> <p>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.</p> <p>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)</p> | <p>1 _____</p> <p>2a \$ _____</p> <p>2b \$ _____</p> <p>2c \$ _____</p> <p>3 _____</p> <p>4 \$ _____</p> |
| Step 4(b) — Deductions Worksheet <i>(Keep for your records.)</i> | |
| <p>1 Enter an estimate of your 2022 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</p> <p>2 Enter: $\left\{ \begin{array}{l} \bullet \\$25,900 \text{ if you're married filing jointly or qualifying widow(er)} \\ \bullet \\$19,400 \text{ if you're head of household} \\ \bullet \\$12,950 \text{ if you're single or married filing separately} \end{array} \right\}$</p> <p>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-"</p> <p>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</p> <p>5 Add lines 3 and 4. Enter the result here and in Step 4(b) of Form W-4</p> | <p>1 \$ _____</p> <p>2 \$ _____</p> <p>3 \$ _____</p> <p>4 \$ _____</p> <p>5 \$ _____</p> |



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 | \$110 | \$850 | \$860 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,020 | \$1,770 | \$1,870 |
| \$10,000 - 19,999 | 110 | 1,110 | 1,860 | 2,060 | 2,220 | 2,220 | 2,220 | 2,220 | 2,220 | 2,970 | 3,970 | 4,070 |
| \$20,000 - 29,999 | 850 | 1,860 | 2,800 | 3,000 | 3,160 | 3,160 | 3,160 | 3,160 | 3,910 | 4,910 | 5,910 | 6,010 |
| \$30,000 - 39,999 | 860 | 2,060 | 3,000 | 3,200 | 3,360 | 3,360 | 3,360 | 4,110 | 5,110 | 6,110 | 7,110 | 7,210 |
| \$40,000 - 49,999 | 1,020 | 2,220 | 3,160 | 3,360 | 3,520 | 3,520 | 4,270 | 5,270 | 6,270 | 7,270 | 8,270 | 8,370 |
| \$50,000 - 59,999 | 1,020 | 2,220 | 3,160 | 3,360 | 3,520 | 4,270 | 5,270 | 6,270 | 7,270 | 8,270 | 9,270 | 9,370 |
| \$60,000 - 69,999 | 1,020 | 2,220 | 3,160 | 3,360 | 4,270 | 5,270 | 6,270 | 7,270 | 8,270 | 9,270 | 10,270 | 10,370 |
| \$70,000 - 79,999 | 1,020 | 2,220 | 3,160 | 4,110 | 5,270 | 6,270 | 7,270 | 8,270 | 9,270 | 10,270 | 11,270 | 11,370 |
| \$80,000 - 99,999 | 1,020 | 2,820 | 4,760 | 5,960 | 7,120 | 8,120 | 9,120 | 10,120 | 11,120 | 12,120 | 13,150 | 13,450 |
| \$100,000 - 149,999 | 1,870 | 4,070 | 6,010 | 7,210 | 8,370 | 9,370 | 10,510 | 11,710 | 12,910 | 14,110 | 15,310 | 15,600 |
| \$150,000 - 239,999 | 2,040 | 4,440 | 6,580 | 7,980 | 9,340 | 10,540 | 11,740 | 12,940 | 14,140 | 15,340 | 16,540 | 16,830 |
| \$240,000 - 259,999 | 2,040 | 4,440 | 6,580 | 7,980 | 9,340 | 10,540 | 11,740 | 12,940 | 14,140 | 15,340 | 16,540 | 17,590 |
| \$260,000 - 279,999 | 2,040 | 4,440 | 6,580 | 7,980 | 9,340 | 10,540 | 11,740 | 12,940 | 14,140 | 16,100 | 18,100 | 19,190 |
| \$280,000 - 299,999 | 2,040 | 4,440 | 6,580 | 7,980 | 9,340 | 10,540 | 11,740 | 13,700 | 15,700 | 17,700 | 19,700 | 20,790 |
| \$300,000 - 319,999 | 2,040 | 4,440 | 6,580 | 7,980 | 9,340 | 11,300 | 13,300 | 15,300 | 17,300 | 19,300 | 21,300 | 22,390 |
| \$320,000 - 364,999 | 2,100 | 5,300 | 8,240 | 10,440 | 12,600 | 14,600 | 16,600 | 18,600 | 20,600 | 22,600 | 24,870 | 26,260 |
| \$365,000 - 524,999 | 2,970 | 6,470 | 9,710 | 12,210 | 14,670 | 16,970 | 19,270 | 21,570 | 23,870 | 26,170 | 28,470 | 29,870 |
| \$525,000 and over | 3,140 | 6,840 | 10,280 | 12,980 | 15,640 | 18,140 | 20,640 | 23,140 | 25,640 | 28,140 | 30,640 | 32,240 |

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 | \$400 | \$930 | \$1,020 | \$1,020 | \$1,250 | \$1,870 | \$1,870 | \$1,870 | \$1,870 | \$1,970 | \$2,040 | \$2,040 |
| \$10,000 - 19,999 | 930 | 1,570 | 1,660 | 1,890 | 2,890 | 3,510 | 3,510 | 3,510 | 3,610 | 3,810 | 3,880 | 3,880 |
| \$20,000 - 29,999 | 1,020 | 1,660 | 1,990 | 2,990 | 3,990 | 4,610 | 4,610 | 4,710 | 4,910 | 5,110 | 5,180 | 5,180 |
| \$30,000 - 39,999 | 1,020 | 1,890 | 2,990 | 3,990 | 4,990 | 5,610 | 5,710 | 5,910 | 6,110 | 6,310 | 6,380 | 6,380 |
| \$40,000 - 59,999 | 1,870 | 3,510 | 4,610 | 5,610 | 6,680 | 7,500 | 7,700 | 7,900 | 8,100 | 8,300 | 8,370 | 8,370 |
| \$60,000 - 79,999 | 1,870 | 3,510 | 4,680 | 5,880 | 7,080 | 7,900 | 8,100 | 8,300 | 8,500 | 8,700 | 8,970 | 9,770 |
| \$80,000 - 99,999 | 1,940 | 3,780 | 5,080 | 6,280 | 7,480 | 8,300 | 8,500 | 8,700 | 9,100 | 10,100 | 10,970 | 11,770 |
| \$100,000 - 124,999 | 2,040 | 3,880 | 5,180 | 6,380 | 7,580 | 8,400 | 9,140 | 10,140 | 11,140 | 12,140 | 13,040 | 14,140 |
| \$125,000 - 149,999 | 2,040 | 3,880 | 5,180 | 6,520 | 8,520 | 10,140 | 11,140 | 12,140 | 13,320 | 14,620 | 15,790 | 16,890 |
| \$150,000 - 174,999 | 2,040 | 4,420 | 6,520 | 8,520 | 10,520 | 12,170 | 13,470 | 14,770 | 16,070 | 17,370 | 18,540 | 19,640 |
| \$175,000 - 199,999 | 2,720 | 5,360 | 7,460 | 9,630 | 11,930 | 13,860 | 15,160 | 16,460 | 17,760 | 19,060 | 20,230 | 21,330 |
| \$200,000 - 249,999 | 2,970 | 5,920 | 8,310 | 10,610 | 12,910 | 14,840 | 16,140 | 17,440 | 18,740 | 20,040 | 21,210 | 22,310 |
| \$250,000 - 399,999 | 2,970 | 5,920 | 8,310 | 10,610 | 12,910 | 14,840 | 16,140 | 17,440 | 18,740 | 20,040 | 21,210 | 22,310 |
| \$400,000 - 449,999 | 2,970 | 5,920 | 8,310 | 10,610 | 12,910 | 14,840 | 16,140 | 17,440 | 18,740 | 20,040 | 21,210 | 22,470 |
| \$450,000 and over | 3,140 | 6,290 | 8,880 | 11,380 | 13,880 | 16,010 | 17,510 | 19,010 | 20,510 | 22,010 | 23,380 | 24,680 |

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 | \$760 | \$910 | \$1,020 | \$1,020 | \$1,020 | \$1,190 | \$1,870 | \$1,870 | \$1,870 | \$2,040 | \$2,040 |
| \$10,000 - 19,999 | 760 | 1,820 | 2,110 | 2,220 | 2,220 | 2,390 | 3,390 | 4,070 | 4,070 | 4,240 | 4,440 | 4,440 |
| \$20,000 - 29,999 | 910 | 2,110 | 2,400 | 2,510 | 2,680 | 3,680 | 4,680 | 5,360 | 5,530 | 5,730 | 5,930 | 5,930 |
| \$30,000 - 39,999 | 1,020 | 2,220 | 2,510 | 2,790 | 3,790 | 4,790 | 5,790 | 6,640 | 6,840 | 7,040 | 7,240 | 7,240 |
| \$40,000 - 59,999 | 1,020 | 2,240 | 3,530 | 4,640 | 5,640 | 6,780 | 7,980 | 8,860 | 9,060 | 9,260 | 9,460 | 9,460 |
| \$60,000 - 79,999 | 1,870 | 4,070 | 5,360 | 6,610 | 7,810 | 9,010 | 10,210 | 11,090 | 11,290 | 11,490 | 11,690 | 12,170 |
| \$80,000 - 99,999 | 1,870 | 4,210 | 5,700 | 7,010 | 8,210 | 9,410 | 10,610 | 11,490 | 11,690 | 12,380 | 13,370 | 14,170 |
| \$100,000 - 124,999 | 2,040 | 4,440 | 5,930 | 7,240 | 8,440 | 9,640 | 10,860 | 12,540 | 13,540 | 14,540 | 15,540 | 16,480 |
| \$125,000 - 149,999 | 2,040 | 4,440 | 5,930 | 7,240 | 8,860 | 10,860 | 12,860 | 14,540 | 15,540 | 16,830 | 18,130 | 19,230 |
| \$150,000 - 174,999 | 2,040 | 4,460 | 6,750 | 8,860 | 10,860 | 12,860 | 15,000 | 16,980 | 18,280 | 19,580 | 20,880 | 21,980 |
| \$175,000 - 199,999 | 2,720 | 5,920 | 8,210 | 10,320 | 12,600 | 14,900 | 17,200 | 19,180 | 20,480 | 21,780 | 23,080 | 24,180 |
| \$200,000 - 449,999 | 2,970 | 6,470 | 9,060 | 11,480 | 13,780 | 16,080 | 18,380 | 20,360 | 21,660 | 22,960 | 24,250 | 25,360 |
| \$450,000 and over | 3,140 | 6,840 | 9,630 | 12,250 | 14,750 | 17,250 | 19,750 | 21,930 | 23,430 | 24,930 | 26,420 | 27,730 |

**Employee Withholding Exemption Certificate (L-4)**

Louisiana Department of Revenue

Purpose: Complete form L-4 so that your employer can withhold the correct amount of state income tax from your salary.

Instructions: Employees who are subject to state withholding should complete the personal allowances worksheet indicating the number of withholding personal exemptions in Block A and the number of dependency credits in Block B.

- Employees must file a new withholding exemption certificate within 10 days if the number of their exemptions decreases, except if the change is the result of the death of a spouse or a dependent.
- Employees may file a new certificate any time the number of their exemptions increases.
- Line 8 should be used to increase or decrease the tax withheld for each pay period. Decreases should be indicated as a negative amount.

Penalties will be imposed for willfully supplying false information or willful failure to supply information that would reduce the withholding exemption.

This form must be filed with your employer. If an employee fails to complete this withholding exemption certificate, the employer must withhold Louisiana income tax from the employee's wages without exemption.

Note to Employer: Keep this certificate with your records. If you believe that an employee has improperly claimed too many exemptions or dependency credits, please forward a copy of the employee's signed L-4 form with an explanation as to why you believe that the employee improperly completed this form and any other supporting documentation. The information should be sent to the Louisiana Department of Revenue, Criminal Investigations Division, PO Box 2389, Baton Rouge, LA 70821-2389.

Block A

- Enter "0" to claim neither yourself nor your spouse, and check "*No exemptions or dependents claimed*" under number 3 below. You may enter "0" if you are married, and have a working spouse or more than one job to avoid having too little tax withheld.
- Enter "1" to claim yourself, and check "*Single*" under number 3 below. If you did not claim this exemption in connection with other employment, or if your spouse has not claimed your exemption. Enter "1" to claim one personal exemption if you will file as head of household, and check "*Single*" under number 3 below.
- Enter "2" to claim yourself and your spouse, and check "*Married*" under number 3 below.

A.**Block B**

- Enter the number of dependents, not including yourself or your spouse, whom you will claim on your tax return. If no dependents are claimed, enter "0."

B.

Cut here and give the bottom portion of certificate to your employer. Keep the top portion for your records.

Form **L-4**Louisiana
Department of
Revenue**Employee's Withholding Allowance Certificate**

| | | | |
|---|--|--|-----|
| 1. Type or print first name and middle initial | | Last name | |
| 2. Social Security Number | | 3. Select one <input type="checkbox"/> No exemptions or dependents claimed <input type="checkbox"/> Single <input type="checkbox"/> Married | |
| 4. Home address (number and street or rural route) | | | |
| 5. City | | State | ZIP |
| 6. Total number of exemptions claimed in Block A | | | 6. |
| 7. Total number of dependents claimed in Block B | | | 7. |
| 8. Increase or decrease in the amount to be withheld each pay period. Decreases should be indicated as a negative amount. | | | 8. |

I declare under the penalties imposed for filing false reports that the number of exemptions and dependency credits claimed on this certificate do not exceed the number to which I am entitled.

Employee's signature

Date

The following is to be completed by employer.

| | |
|--------------------------------|---|
| 9. Employer's name and address | 10. Employer's state withholding account number |
|--------------------------------|---|

Request for Taxpayer Identification Number and Certification

Give Form to the
requester. Do not
send to the IRS.

► Go to www.irs.gov/FormW9 for instructions and the latest information.

| | | |
|--|---|---|
| Print or type. See Specific Instructions on page 3. | 1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank. | |
| | 2 Business name/disregarded entity name, if different from above | |
| | 3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ► _____ | 4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i> |
| | 5 Address (number, street, and apt. or suite no.) See instructions. | Requester's name and address (optional) |
| | 6 City, state, and ZIP code | |
| | 7 List account number(s) here (optional) | |

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

| | | | | | | | | | | | | |
|--------------------------------|--|--|--|---|---|--|--|---|--|--|--|--|
| Social security number | | | | | | | | | | | | |
| | | | | - | | | | - | | | | |
| or | | | | | | | | | | | | |
| Employer identification number | | | | | | | | | | | | |
| | | | | | - | | | | | | | |

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

| | | |
|-----------|----------------------------|--------|
| Sign Here | Signature of U.S. person ► | Date ► |
|-----------|----------------------------|--------|

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting*, later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, *Withholding of Tax on Nonresident Aliens and Foreign Entities*).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the instructions for Part II for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code*, later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships*, earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code*, later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

| IF the entity/person on line 1 is a(n) . . . | THEN check the box for . . . |
|--|---|
| • Corporation | Corporation |
| • Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes. | Individual/sole proprietor or single-member LLC |
| • LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes. | Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation) |
| • Partnership | Partnership |
| • Trust/estate | Trust/estate |

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

- 1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2—The United States or any of its agencies or instrumentalities
- 3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities
- 4—A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5—A corporation
- 6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession
- 7—A futures commission merchant registered with the Commodity Futures Trading Commission
- 8—A real estate investment trust
- 9—An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10—A common trust fund operated by a bank under section 584(a)
- 11—A financial institution
- 12—A middleman known in the investment community as a nominee or custodian
- 13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

| IF the payment is for . . . | THEN the payment is exempt for . . . |
|--|---|
| Interest and dividend payments | All exempt payees except for 7 |
| Broker transactions | Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012. |
| Barter exchange transactions and patronage dividends | Exempt payees 1 through 4 |
| Payments over \$600 required to be reported and direct sales over \$5,000 ¹ | Generally, exempt payees 1 through 5 ² |
| Payments made in settlement of payment card or third party network transactions | Exempt payees 1 through 4 |

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester*, later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at www.SSA.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/Businesses and clicking on Employer Identification Number (EIN) under Starting a Business. Go to www.irs.gov/Forms to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to www.irs.gov/OrderForms to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code*, earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.

You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

| For this type of account: | Give name and SSN of: |
|--|---|
| 1. Individual | The individual |
| 2. Two or more individuals (joint account) other than an account maintained by an FFI | The actual owner of the account or, if combined funds, the first individual on the account ¹ |
| 3. Two or more U.S. persons (joint account maintained by an FFI) | Each holder of the account |
| 4. Custodial account of a minor (Uniform Gift to Minors Act) | The minor ² |
| 5. a. The usual revocable savings trust (grantor is also trustee) | The grantor-trustee ¹ |
| b. So-called trust account that is not a legal or valid trust under state law | The actual owner ¹ |
| 6. Sole proprietorship or disregarded entity owned by an individual | The owner ³ |
| 7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A)) | The grantor* |
| For this type of account: | Give name and EIN of: |
| 8. Disregarded entity not owned by an individual | The owner |
| 9. A valid trust, estate, or pension trust | Legal entity ⁴ |
| 10. Corporation or LLC electing corporate status on Form 8832 or Form 2553 | The corporation |
| 11. Association, club, religious, charitable, educational, or other tax-exempt organization | The organization |
| 12. Partnership or multi-member LLC | The partnership |
| 13. A broker or registered nominee | The broker or nominee |

| For this type of account: | Give name and EIN of: |
|---|-----------------------|
| 14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments | The public entity |
| 15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B)) | The trust |

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships*, earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at spam@uce.gov or report them at www.ftc.gov/complaint. You can contact the FTC at www.ftc.gov/idtheft or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see www.IdentityTheft.gov and Pub. 5027.

Visit www.irs.gov/IdentityTheft to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.



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> | |
| <p><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></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p> | |
| QR Code - Section 1 Do Not Write In This Space | |

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

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 | | |
| Employer's Business or Organization Address (Street Number and Name) | City or Town | State | ZIP Code | |

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) |
|----------------|-----------------|---------------------------------------|

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 |
|--|---------------------------|---|

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 | | LIST B | LIST C |
|---|---------------------------------------|---|---|
| Documents that Establish Both Identity and Employment Authorization | OR | Documents that Establish Identity | Documents that Establish Employment Authorization |
| | | | AND |
| 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 a nonimmigrant alien authorized to work for a specific employer because of his or her status: 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 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. | | 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 |
| | | 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: | |
| 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 | | 10. School record or report card | |
| | | 11. Clinic, doctor, or hospital record | |
| | 12. Day-care or nursery school record | | |

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

Refer to the instructions for more information about acceptable receipts.

**DIOCESE OF LAKE CHARLES
FORM 1, APPLICATION FOR EMPLOYMENT**

BY SUBMITTING THIS APPLICATION, YOU ARE AUTHORIZING A CRIMINAL BACKGROUND CHECK OF YOURSELF. THIS CHECK WILL BE MADE FROM PUBLIC RECORD SOURCES. YOU WILL HAVE AN OPPORTUNITY TO REVIEW AND CHALLENGE ANY ADVERSE INFORMATION DISCLOSED BY THE CHECK.

**414 Iris Street – Lake Charles, Louisiana 70601
Telephone: (337) 439-7400 - Fax: (337) 439-7413
Web Site: www.lcdiocese.org**



Application for Employment

Diocese of Lake Charles

P. O. Box 3223
Lake Charles, LA 70602
(337)-439-7400

In compliance with federal and state equal employment opportunity laws, qualified applicants are considered for all positions without regard to race, color, sex, national origin, age, marital status, or the presence of a non job-related medical condition or handicap. There may occasionally be positions vacant, which require knowledge of the Catholic faith. In those circumstances, knowledge of the faith becomes a qualification, but it is not always necessary that the applicant be Catholic.

Position Applying for _____

Date Available for Employment _____ Minimum Acceptable Salary _____

Will this position involve any contact or work with minors? Yes _____ No _____

Name _____ Social Security No. _____ - _____ - _____

Street Address _____ City, State, Zip _____

Home Phone Number (____) _____ Work Phone Number (____) _____

Are you 18 or over? Yes _____ No _____

Are you available for Full-time _____ Part-time _____ Temporary _____
Day _____ Evening _____ Weekends _____

Do you have a valid driver's license? Yes _____ No _____

Do you have transportation at your disposal? Yes _____ No _____

Has your driver's license ever been suspended or revoked? Yes _____ No _____

Do you use illegal drugs? Yes _____ No _____

Have you ever been accused of, or has a civil or criminal complaint ever been filed against you, alleging sexual abuse, or neglect of a minor? Yes _____ No _____

Have you ever been convicted of a felony? Yes _____ No _____

If yes, please give details: _____

Have you ever worked in a Church parish before? Yes _____ No _____

If yes, where, when, and in what capacity? _____

EDUCATION

Highest grade completed: _____ High School Diploma _____ General Equivalency Diploma _____

Name of High School _____

Location _____

College/University

Name _____ Dates Attended _____ to _____

Location _____ Degree _____ Major _____

Graduate School

Name _____ Dates Attended _____ to _____

Location _____ Degree _____ Major _____

Other Schools Attended (business, trade, military)

Name _____ Dates Attended _____ to _____

Location _____ Did you complete the course of study? Yes ___ No ___

If yes, license or certificate received: _____

BUSINESS SKILLS

Can you type? Yes ___ No ___ WPM _____ Word Processing? Yes ___ No ___

Computer applications used: _____

Business skills (Please specify)

BUSINESS/COMMUNITY ORGANIZATIONS WITH WHICH YOU ARE AFFILIATED (only those related to your position): _____

Do you have any relatives employed by the parish? Yes ___ No ___

If yes, please list their name(s), relationship, and their position with the Parish. _____

WORK EXPERIENCE

(List present and past employment beginning with your most recent employment. If additional space is needed, please use a sheet of paper and attach.)

| | | | |
|--|----------|--------|--|
| Employer Name, Address, and Phone Number | Position | Duties | |
| | From | | |
| | To | | |
| | Salary | | |
| Reason for Leaving | | | |
| Supervisor | | | |

May we contact your current employer? Yes ___ No ___

| | | |
|---|----------|--------|
| Employer Name, Address, and Phone Number | Position | Duties |
| | From | |
| | To | |
| | Salary | |
| Reason for Leaving | | |
| Supervisor | | |
| May we contact your previous employer? Yes _____ No _____ | | |

REFERENCES: Personal and Professional

Please provide three personal references, all of whom have knowledge of your character and professional skills in the spaces below. Do not include relatives.

| NAME | ADDRESS | PHONE NUMBER |
|------|---------|--------------|
| | | |
| | | |
| | | |

THE FOLLOWING IS AN IMPORTANT PART OF THE APPLICATION AND SHOULD BE READ CAREFULLY.

I understand that if employed by the Diocese of Lake Charles my acceptance of employment does not constitute an employment contract and no agreement to the contrary (written, stated, or implied) will be recognized unless entered into with the Chancellor. I understand that my employment shall depend on satisfactory replies from my references and current and former employers. I understand that the information I have provided shall be verified by contacting any person or organization that may have information concerning me. I also understand that if my responsibilities/ministry involves contact with minors, I must undergo a criminal background check. I agree to abide by the rules, and policies of the Diocese of Lake Charles.

I authorize the Diocese of Lake Charles to verify any statements made by me on this application and on any other form(s) completed by me. I authorize all persons having knowledge of me or my records to release such information to the Diocese of Lake Charles. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to hold harmless the Diocese of Lake Charles, and the officers, employees, and volunteers thereof, from any and all liability or claims that may arise from such disclosures or investigations.

I certify that the statements made by me on this application are true, complete and correct and it is further understood that should any falsification be discovered it will constitute grounds for non-acceptance or for dismissal.

Applicant's Signature

Date

DOB: _____ (This information is for statistical purposes only. Your age is not a criteria for hiring.)

Diocese of Lake Charles

FORM 11, VOLUNTEER PROFILE

Name of Church Parish: _____

Service/Ministry Volunteering For: _____ Date Available _____

Will this position involve any contact or work with minors? Yes _____ No _____

Name _____ Social Security No. _____ - _____ - _____

Street Address _____ City, State, Zip _____

Home Phone Number (_____) _____ Work Phone Number: (_____) _____

Are you 18 or over? Yes _____ No _____

Are you available for: Full-time _____ Part-time _____ Temporary _____

Day _____ Evening _____ Weekends _____

Do you have a valid driver's license? Yes _____ No _____

Do you have transportation at your disposal? Yes _____ No _____

Has your driver's license ever been suspended or revoked? Yes _____ No _____

Do you use illegal drugs? Yes _____ No _____

Have you ever been accused of, or has a civil or criminal complaint ever been filed against you, alleging sexual abuse, or neglect of a minor? Yes _____ No _____

Have you ever been convicted of a felony? Yes _____ No _____

If yes, please give details _____

Have you ever volunteered in a Church parish before? Yes _____ No _____

If yes, where, when, and in what capacity? _____

Emergency Contact Information:

Name of closest relative: _____ Telephone Number: _____

Name of employer: _____ Telephone Number: _____

Please provide two personal references on the second page of this form.

Form 11

THE FOLLOWING IS AN IMPORTANT PART OF THE PROFILE AND SHOULD BE READ CAREFULLY.

I understand that acceptance of my services by the church parish does not constitute an employment contract and no agreement to the contrary (written, stated, or implied) will be recognized unless entered into with the pastor. I understand that the information I have provided may be verified, if necessary, by contacting any person or organization that may have information concerning me. I also understand that if my responsibilities/ministry involves contact with minors, I must undergo a criminal background check. I agree to abide by the rules and policies of the Diocese of Lake Charles and the church parish and while the parish may have in effect certain personnel procedures and practices, neither the existence of the procedures and practices, nor the parish's use or failure to use them, creates any obligation between the parish and myself. I understand that my services are for no definite period and may be terminated with or without notice, at any time, for any reason, or no reason, by the pastor or myself. I further understand that the hours of service will be flexible as deemed necessary by the pastor.

I authorize the Diocese of Lake Charles and/or the church parish to verify any statements made by me on this profile and on any other form(s) completed by me. I authorize all persons having knowledge of me or my records to release such information to the parish. I hereby release and agree to hold harmless from liability any person or organization that provides information. I also agree to hold harmless the Diocese of Lake Charles, the church parish and the officers, employees, and volunteers thereof, from any and all liability or claims that may arise from such disclosures or investigations.

I certify that the statements made by me on this profile are true, complete and correct and it is further understood that should any falsification be discovered it will constitute grounds for non-acceptance of or for termination of my services.

Volunteer's Signature

Date

PERSONAL REFERENCES

Please list those who are familiar with your character as it relates to your Christian faith and volunteer activities, and especially if applicable, as it relates to working with youth.

NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE NO. _____

NAME: _____

ADDRESS: _____


CITY/STATE/ZIP: _____

TELEPHONE NO. _____

Diocese of Lake Charles
Safe Environment Training
Instructions for
ALL Clergy, Staff, Religious & Volunteers

All volunteers, staff, religious and clergy may complete the annual diocesan safe environment training requirement through the **Safe & Sacred™ Environment Training Program**.

- † The program is designed to be respectful of the topic and your time. It should only take about one hour to complete.
- † The site is accessible anytime and on almost all computers and Internet connections.
- † If you have any questions or problems there is a button at the **top right corner of almost every screen** where there is a "live" person waiting to answer your questions.
- † You may also contact Technical Support by calling toll-free: 888-804-9643.

 **Click for Live Help**

It is as easy as...

1. Create a user profile at the training web site: <http://safeandsacred-lcdiocese.org>

Important: Be sure to save your user name and password, so you can return to the website for future training programs.

Safe And Sacred login may also be accessed from lcdiocese.org home page by scrolling all the way down to the bottom left corner and pressing on the words Safe Environment.

When choosing fields to create your account please read **ALL** options before selecting one. It is very important to select the correct fields in order to have accurate counts at diocesan audit time.

2. Complete the "Recognizing Child Abuse" course online at your convenience.

Be sure to read the instructions and complete all of the steps:

- Review the training program.
- Complete the 10 question quiz. (You have as many attempts as needed.)
- Review the Diocesan Policies & Code of Professional Conduct.
- Complete the Make the Commitment activity.
- Print the Contact Card. (optional)

3. Print and hand in your Certificate of Completion to the Safe Environment Coordinator at your location.

You may also email your certificate from the site to the email address listed below:

Parish/School SE Coordinator's email may be entered here

Everyone who works with young people and/or vulnerable adults shares the responsibility of creating safe environments. We are all charged with treating life with the respect and dignity given to each of us by our Creator.

Thank you for taking the time to complete this important training.



**DIOCESE OF LAKE CHARLES
CRIMINAL RECORD CHECK
Office of Child & Youth Protection**

411 Iris Street ♦ Lake Charles LA 70601 ♦ 337-439-7426 ♦ 337-439-7428 (fax)

The Diocese of Lake Charles will conduct a Criminal History Check for the following person. Please mail or deliver this form to the diocesan OCYP address above where this information will be kept strictly confidential.

(Please Print all information, except for signature)

Last Name: _____ First Name: _____ Middle: _____

(Please include maiden name and list any other names used in the past.) _____

Social Security #: _____ Date of Birth: _____

(For photo identification purposes only) Gender: _____ Race: _____

Physical Address: _____

City, State, Zip Code: _____

Email Address: _____

Name/Location of Diocesan School, Parish, Institution: _____

Other than your current address, list your former residence(s), for the past five (5) years: (If additional space is needed, please use back of page.)

| Parish/County | State | Year(s) of Residence |
|---------------|-------|----------------------|
| | | |
| | | |

Have you ever been accused of, or has a civil or criminal complaint ever been filed against you, alleging physical, emotional, or sexual abuse of a minor? Yes _____ No _____

Have you ever been convicted of a felony? Yes _____ No _____

If yes, please give details _____

I have read the SAFE ENVIRONMENT POLICIES and CODE OF CONDUCT for the Diocese of Lake Charles and I agree to observe all policy guidelines.

As an employee or volunteer in Diocese of Lake Charles, I understand a thorough investigation of any record of past criminal activity will be conducted.

By my signature below, I hereby authorize such an investigation and further authorize the Sheriff's Office, the Louisiana State Police, the Louisiana Department of Public Safety and Corrections, or any other law enforcement agency to release all pertinent criminal record information maintained in their files which may confirm or deny my eligibility for employment/volunteer service with the Diocese of Lake Charles.

Applicant's Signature: _____ Date: _____

*****OFFICE USE ONLY*****

CRIMINAL HISTORY WAS: FOUND NOT FOUND



1001 North 23rd Street
Post Office Box 44187
Baton Rouge, LA 70804-4187

(O) 225-342-7866
800-201-2493
(F) 225-219-5968

John Bel Edwards, Governor
Ava Dejoie, Executive Director

Office of Workers' Compensation Administration
Second Injury Board

LA OWCA Second Injury Board Knowledge Questionnaire

The following questionnaire should only be completed by individuals that have been hired for employment. Your employer may ask that you complete this questionnaire following your initial hire and periodically thereafter.

The questionnaire may be used in the establishment of prior knowledge for the purpose of obtaining Second Injury Fund relief from the Second Injury Board. The Second Injury Board may reimburse your employer for workers' compensation claims that meet certain criteria should you become injured on the job. This reimbursement in no way affects the benefits owed to you by your employer or their insurance company under the Louisiana Workers' Compensation Act, La. R.S. 23:1021-1361.

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

Employer: _____

Employee Name: _____

Date of Birth (mm/dd/yyyy): _____ Male: ☐ Female: ☐

Soc. Sec. # (last 4 digits only): _____

Home Address: _____

Telephone Number: (____) _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

PAGE ____ OF ____

SIB FORM D 10/10

Please place a check in the appropriate box next to each medical condition listed below. Each illness or condition requires a Yes (Y) or No (N) answer. For all conditions that you check yes, write a brief explanation on the Explanation Page.

Disease and Other Medical Conditions [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

| Y N | Y N | Y N | Y N |
|---|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Attack |
| <input type="checkbox"/> <input type="checkbox"/> Silicosis | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Parkinson's | <input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> <input type="checkbox"/> Brain Damage | <input type="checkbox"/> <input type="checkbox"/> Vision Loss, one or both eyes |
| <input type="checkbox"/> <input type="checkbox"/> Asbestosis | <input type="checkbox"/> <input type="checkbox"/> Post Traumatic Stress | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Disability from Polio |
| <input type="checkbox"/> <input type="checkbox"/> Hyperinsulinism | <input type="checkbox"/> <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> <input type="checkbox"/> Dementia | <input type="checkbox"/> <input type="checkbox"/> Psychoneurotic Disability |
| <input type="checkbox"/> <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> <input type="checkbox"/> Nervous Disorder | <input type="checkbox"/> <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> <input type="checkbox"/> Ruptured or Herniated Disc |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> <input type="checkbox"/> Ankylosis or Joint Stiffening |
| <input type="checkbox"/> <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> <input type="checkbox"/> Hodgkin's | <input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> <input type="checkbox"/> COPD | <input type="checkbox"/> <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Carpal Tunnel Syndrome |
| <input type="checkbox"/> <input type="checkbox"/> Hypertension | <input type="checkbox"/> <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> <input type="checkbox"/> Double Vision | <input type="checkbox"/> <input type="checkbox"/> Compressed Air Sequelae |
| <input type="checkbox"/> <input type="checkbox"/> Head Injury | <input type="checkbox"/> <input type="checkbox"/> Loss of Use of Limb | <input type="checkbox"/> <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> <input type="checkbox"/> Disease of the Lung |
| <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> <input type="checkbox"/> Heavy Metal Poisoning |

Surgical Treatment [Please check the appropriate box. Each illness/injury requires a Yes (Y) or No (N) answer.]

Y N

| | |
|--|---|
| <input type="checkbox"/> <input type="checkbox"/> Spinal Disc Surgery | Year (approximate if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Spinal Fusion Surgery | Year (approximate if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Amputated Foot | Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Amputated Leg | Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Amputated Arm | Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Amputated Hand | Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Knee Replacement | Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Hip Replacement | Left <input type="checkbox"/> Right <input type="checkbox"/> Year (approx. if unsure) _____ |
| <input type="checkbox"/> <input type="checkbox"/> Other Joint Replacement | Joint _____ Year _____ |
| <input type="checkbox"/> <input type="checkbox"/> Other Surgical Procedure | Procedure _____ Year _____ |

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

EXPLANATION PAGE

Please use the space below to explain the illnesses and/or conditions that you checked a Yes (Y) or any other medical conditions that may not be listed on this form. Ask your employer for additional copies of this page if needed.

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

CONDITION: _____ Year Diagnosed (approx): _____

Are you still treating for this condition? Yes ☐ No ☐

Are you taking medication for this condition? Yes ☐ No ☐

Do you have any permanent restrictions for this condition? Yes ☐ No ☐

Brief Explanation: _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

Please answer the following questions.

1. Has any doctor ever restricted your activities? Yes ☐ No ☐

If "Yes," please list the restrictions: _____

Were the restrictions: Permanent _____ Temporary _____

Are you currently restricted? Yes ☐ No ☐

What is the medical condition for which you are restricted? _____

2. Are you presently treating with a doctor, chiropractor, psychiatrist, psychologist or other health-care provider? Yes ☐ No ☐

Please list the medical condition being treated: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

3. If you are presently taking prescription medication other than those listed on the Explanation Page, please complete the requested information below.

Medication: _____ Prescribing Doctor: _____

Medication: _____ Prescribing Doctor: _____

4. Have you ever had an on the job accident? Yes ☐ No ☐

If you answered "YES," please provide the date for each injury and the nature of the injury:

How long were you on compensation? _____

Name of Employer: _____

5. Has a doctor recommended a surgical procedure, which has not been completed prior to this date, including but not limited to knee, hip or shoulder replacement? Yes ☐ No ☐

If you answered YES, please provide:

Recommended surgery: _____

Approximate date of recommendation: _____

Doctor's Name: _____ Specialty: _____

Doctor's Address: _____

Employee Signature: _____ Date: _____

Employer Witness: _____ Date: _____

WARNING

FAILURE TO ANSWER TRUTHFULLY AND/OR CORRECTLY TO ANY OF THE QUESTIONS ON THIS FORM MAY RESULT IN A FORFEITURE OF YOUR WORKERS COMPENSATION BENEFITS UNDER LA R.S. 23:1208.1.

I have completed this form honestly and to the best of my knowledge. I understand that providing false information or omitting pertinent information could result in loss of my workers compensation benefits should I become injured on the job.

Employee Signature: _____ Date: _____

Employee Printed: _____

I am an authorized representative of the employer designated to obtain and review the information provided by the employee on this questionnaire. I have confirmed that the employee understands the consequences associated with providing false information or omitting pertinent information. I have confirmed that the employee is able to read and understand the information provided on this questionnaire or I have personally read the questionnaire to the employee. I have provided the employee with as many copies of the Explanation Page as needed. I have confirmed the number of and labeled the pages of this questionnaire.

Employer Witness: _____ Date: _____

Employer Witness Printed: _____

Title: _____

DAILY ATTENDANCE RECORD

FISCAL YEAR: 2022-2023

| NAME | | DEPARTMENT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-----------|---|------------|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----------|-----|--------|---|----|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DATE: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | SEC | DIR | 0 | 0 | 0 | 0 | 0 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | B | C | AC | P | S | V | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JULY | | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| AUGUST | | | | | | W | W | | | | | | W | W | | | | | W | W | | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SEPTEMBER | | | W | W | | | | | | W | W | | | | | W | W | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OCTOBER | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOVEMBER | | | | | W | W | | | | | | W | W | | | | | W | W | | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DECEMBER | | | W | W | | | | | | W | W | | | | | W | W | | | | | | W | W | | | | | | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JANUARY | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEBRUARY | | | | W | W | | | | | | W | W | | | | | W | W | | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MARCH | | | | W | W | | | | | | W | W | | | | | W | W | | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| APRIL | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| MAY | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| JUNE | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | W | W | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Remaining | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Paydate:

Regular Hours: Holiday Hours: Total Hours:
ABSENCE CODES

- W = Weekend
- P = Personal Leave
- Supervisors & Directors, Only
- B = Birthday
- S = Sick Leave
- C = Conferences
- H = Holiday
- V = Vacation
- AL = Approved Leave
- F = Funeral
- D = Disaster
- BW = BAD WEATHER

EMPLOYMENT DATE:

TERMINATION DATE:

This record should be filed at year end in the employee's permanent record file.

YEAR END PAYROLL CHECKLIST

Parish:

2022 1099s:

1. _____ Employer's name, address and identification numbers are correct
2. _____ 1099 vendor forms are correct
3. _____ 1096 totals are correct
4. _____ Diocese of Lake Charles will file Federal Forms 1096 and 1099

If any of the above are incorrect, indicate corrections below:

Signed by:_____

Date:_____

CHECKLIST FOR USE IN PREPARING TAX RETURNS FOR PRIESTS

2022

INDICATE RECOGNITION OF EACH OF THE ITEMS BELOW BY CHECKING:

_____ W-2 WAGES ARE SUBJECT TO SELF EMPLOYMENT TAXES (SCHEDULE SE).
NOTE, THERE ARE NO SOCIAL SECURITY WAGES OR TAXES ON YOUR W-2. SELF-
EMPLOYMENT TAXES REPLACE SOCIAL SECURITY TAXES.

_____ HOUSING ALLOWANCE OF \$400 PER MONTH (\$4800 ANNUALLY) IS NOT
REFLECTED ON THE W-2 AND IS SUBJECT TO SELF EMPLOYMENT TAX, BUT NOT
FEDERAL INCOME TAX.

_____ THE MONTHLY BUSINESS ALLOWANCE OF \$510 (\$6120 ANNUALLY) IS
CONSIDERED AN "ACCOUNTABLE" REIMBURSEMENT OF BUSINESS EXPENSES AND IS
NOT REFLECTED ON THE W-2.

PRIEST

TAX PREPARER

IF THERE ARE ANY QUESTIONS, CONTACT MELANIE FOREMAN AT 439-7400, EXT 206 OR
JACOB TROUTMAN, EXT 213.

PLEASE SIGN & RETURN TO:

DIOCESE OF LAKE CHARLES
ATTN: REV RUBEN BULLER
PO BOX 3223
LAKE CHARLES, LA 70602

BUSINESS REIMBURSEMENT FORM

JANUARY 1, 2022 – DECEMBER 31, 2022

| MONTH_____ | MONTH_____ | MONTH _____ |
|--|--|--|
| Carry-over from last month: \$_____ | Carry over from last month: \$_____ | Carry over from last month: \$_____ |
| AUTOMOBILE | AUTOMOBILE | AUTOMOBILE |
| _____miles @ 58.5 cents \$_____ | _____miles @ 58.5 cents \$_____ | _____miles @ 58.5 cents \$_____ |
| Books \$_____ | \$_____ | \$_____ |
| Subscriptions \$_____ | \$_____ | \$_____ |
| Dues \$_____ | \$_____ | \$_____ |
| Clerical clothing \$_____ | \$_____ | \$_____ |
| Vestments \$_____ | \$_____ | \$_____ |
| Dry cleaning \$_____ | \$_____ | \$_____ |
| Office supplies \$_____ | \$_____ | \$_____ |
| Food/Meals not reimbursed * | \$_____ | \$_____ |
| OTHER \$_____ | \$_____ | \$_____ |
| TOTAL \$_____ | \$_____ | \$_____ |
| Less \$510 \$_____ | \$_____ | \$_____ |
| Carry over to next month \$_____ | \$_____ | \$_____ |

THE BACK OF THIS FORM MAY BE USED FOR NOTES OR RECORD KEEPING

* This is for “out of pocket” purchases of food used in entertaining or for food eaten on the Church campus.

Form developed 21 Nov. 03

SUBSECTION C

HEALTH INSURANCE

1. Continuing Coverage (with informational memo)
2. Continuation of Health Benefits Form
3. Application for Coverage
4. Continuation of Coverage under COBRA or State Group
5. Coverage Cancellation Form
6. CONEXIS Form
7. Claim Form
8. Cafeteria Benefit Plan (to use when an employee elects dependent coverage)
9. Paid Prescription Reimbursement Form
10. Authorized Delegate Form
11. Dependent Certification
12. Checklist for Continuation of Coverage

TO: ALL DIOCESAN LOCATIONS

FROM: PATRICIA A. MYERS, DIRECTOR OF FISCAL AFFAIRS

DATE: JULY 1, 2018

RE: GROUP HEALTH INSURANCE CONTINUATION OF COVERAGE

IMPORTANT: BY THE LAST DAY OF EMPLOYMENT OR THE LAST DAY AN EMPLOYEE IS PAID EMPLOYEE MUST SIGN THIS FORM, INDICATING THAT THEY HAVE BEEN INFORMED OF THE DIOCESE OF LAKE CHARLES' GROUP HEALTH INSURANCE CONTINUATION POLICY AND INFORMED ABOUT THE FEDERALLY FACILITATED MARKETPLACE. (A copy of this completed form should be given to the employee; a copy should remain in employee's personnel file at your office; and a copy should be forwarded to our office.)

The Diocese of Lake Charles Employee Health Insurance Program, administered by Blue Cross Blue Shield of Louisiana, provides the privilege for covered employees to request continuation of health coverage for up to a maximum of twelve (12) months immediately following the last day of the month for which the employer had paid an employee's premium. This privilege is also extended to the employee's covered family members, under the provisions of the plan for said employees. Employees must pay the premiums for this group health insurance continuation.

An ex-employee whose employment ends in the fiscal year beginning July 1, 2018 may request continuation of health coverage for up to 12 months, if such individual has been continuously insured under the Diocese of Lake Charles' Plan for three consecutive months prior to the end of employment and meets the other requirements of the Plan, by paying a premium of \$901.00 per month. Dependent coverage may be continued if such dependent coverage has been continuously in place under the Diocese of Lake Charles' Plan for three consecutive months prior to the end of employment and the ex-employee pays an additional premium of \$1,024.00 per month. Such ex-employees and dependents will receive the same benefits, and will be subjected to the same plan provisions, as active employees. Any change in Plan premiums shall apply to persons on group health insurance continuation. The covered benefits and dependent eligibility will remain the same as those for active employees.

Notification of the group health insurance continuation privilege must be given to every employee prior to the last day of employment or the last day an employee is paid.

1. Group health insurance continuation is only available to employees (and dependents) who have been continuously insured under the Diocese of Lake Charles' Plan for three consecutive months prior to the last day of employment or the last day the ex-employee is paid.
2. Group health insurance continuation is not required to be made available to any ex-employee who is or could be covered by any other type of hospital, surgical, or medical coverage for individuals in a group within thirty-one days following the last day of employment or the last day the ex-employee is paid.

The Diocese of Lake Charles is not required to issue, maintain, or renew coverage for an ex-employee covered by similar benefits of another policy, contract, medical practice prepayment plan or other type of plan, if the ex-employee could be covered under any arrangement for

coverage of individuals in a group, or if coverage is available under any state or federal law. The Diocese of Lake Charles may request information as to whether any of these situations exist.

Any request for such information must be responded to immediately.

Group health insurance continuation may be discontinued for failure to provide this information or for fraud or material misrepresentation in applying for benefits under the group health insurance continuation policy.

If, after an ex-employee elects to continue health coverage, the ex-employee becomes eligible for another group health plan coverage or Medicare he or she MUST notify the Employer, in writing. If the ex-employee does not, he or she may be subject to a tax penalty.

3. Group health insurance continuation is not required to be made available to any employee whose insurance was terminated for fraud.
4. Group health insurance continuation does not include dental, vision care, or any other benefits provided under the group policy in addition to its hospital, surgical, or major medical benefits.
5. An ex-employee who chooses group health insurance continuation must pay, in advance, to the Diocese of Lake Charles the amount of the first month's premium for continued coverage. All continued benefits are canceled unless premiums are paid in advance.
6. Except for the first premium covered by number seven (7) below, the Diocese of Lake Charles or its designee must receive premiums no later than the 20th day of the month prior to each month for which coverage is requested. **PREMIUM NOTICES WILL BE SENT TO THE INSURED BY THE DIOCESE'S DESIGNEE.**
7. In order to be eligible for group health insurance continuation, the ex-employee must make a written election on a form furnished by the employer.

Also, in order to be eligible for group health insurance continuation, the completed CONTINUATION OF HEALTH BENEFITS FORM, along with the first month's premium, must be received by the Diocese of Lake Charles on or before the 20th day of the month in which the employee's insurance would otherwise terminate.

8. Group health insurance continuation shall terminate on the earliest of the following dates:
 - A. The date twelve (12) months after the date the ex-employee's insurance under the policy would otherwise have terminated because of the end of employment.
 - B. The date ending the period for which the ex-employee last pays a premium, if the ex-employee discontinues paying premiums.
 - C. The date the ex-employee "becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured."
 - D. The date on which the Diocese of Lake Charles' policy is terminated.

_____ I DECLINE group health insurance continuation with the Diocese of Lake Charles and acknowledge I have been provided information about the Federally Facilitated Marketplace.

_____ I REQUEST group health insurance continuation with the Diocese of Lake Charles. (If you request continuation of coverage complete the CONTINUATION OF HEALTH BENEFITS FORM.)

Under the Affordable Care Act (ACA) an employee who loses group health insurance coverage because of a "qualified event", like being terminated or having their hours reduced, is eligible for a special enrollment period which may enable them to apply for individual healthcare coverage on the Federally Facilitated Marketplace. Through the Marketplace the employee can also find out if they qualify for help with out-of-pocket costs or even free or low-cost coverage from Medicaid. Additional information concerning the Marketplace is available at www.healthcare.gov.

INITIAL:

_____ I ACKNOWLEDGE information about the Federally Facilitated Marketplace has been provided to me.

Signed: _____ Date: _____

EMPLOYEE

Member # _____

Signed: _____ Date: _____

EMPLOYER

Parish or School: _____

DIOCESE OF LAKE CHARLES
CONTINUATION OF HEALTH BENEFITS FORM

Ex-employees are required to submit a written request, along with premium, by the 20th day of the month preceding the month for which extended coverage is requested. (Filing of this form with our office will serve as an official written request for continuation of coverage.)

Name: _____ Member No. _____

Address: _____

Phone: _____

The last day of my employment, or the last day I will be is paid by

_____ EMPLOYER
will be _____ DATE. My diocesan health coverage will terminate _____ DATE

I would like extended coverage for: (Please check)

_____ Self _____ Present Covered Dependents

I request coverage for the following month(s). Please () and indicate year.

| | |
|--------------------|---------------------|
| () January _____ | () July _____ |
| () February _____ | () August _____ |
| () March _____ | () September _____ |
| () April _____ | () October _____ |
| () May _____ | () November _____ |
| () June _____ | () December _____ |

I am enclosing a check/money order in the amount of \$ _____, made payable to "CONEXIS".

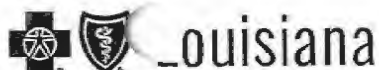
Signed: _____ Date: _____
EMPLOYEE

Signed: _____ Date: _____
EMPLOYER

Signed: _____ Date: _____
PATRICIA A. MYERS, PLAN ADMINISTRATOR

PREMIUMS FOR SUBSEQUENT MONTHS MUST BE RECEIVED BY THE DIOCESE'S DESIGNEE, CONEXIS, NO LATER THAN THE 20TH DAY OF THE MONTH PRIOR TO EACH MONTH FOR WHICH CONTINUED COVERAGE IS REQUESTED. ALL CONTINUED BENEFITS ARE CANCELED UNLESS PREMIUMS ARE PAID IN ADVANCE. CHECKS SHOULD BE MADE PAYABLE TO CONEXIS AND FORWARDED TO: P.O. Box 14225, Orange, CA 92863-1225.

Submit this request, with the first month's premium payment, to: DIOCESE OF LAKE CHARLES Patricia A. Myers, Plan Administrator P.O. Box 3223 Lake Charles, La. 70602-3223



☐ **EMPLOYEE ENROLLMENT** ☐ **EMPLOYEE CHANGE FORM**

PLEASE PRINT AND COMPLETE IN BLACK INK ONLY

Group Number/Subgroup

SECTION A - COVERAGE SELECTIONS

Blue Cross and Blue Shield of Louisiana

- ☐ GroupCare PPO (Plan) _____
☐ BlueSaver (Plan) _____
☐ Premier Blue (Plan) _____
☐ True Blue (Plan) _____

HMO Louisiana, Inc.*

- ☐ HMO (Plan) _____
☐ Blue POS (Plan) _____
☐ Community Blue POS (Plan) _____
☐ BlueConnect POS (Plan) _____
☐ Signature Blue POS (Plan) _____
☐ BlueConnect Savings Plus (Plan) _____

- ☐ Dental (Plan) _____
☐ Vision (Plan) _____

Southern National Life Insurance Company, Inc.

- ☐ Group Term Life
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability
☐ Voluntary Life
☐ Voluntary High Limit AD&D

SECTION A-2 - AXA COVERAGE SELECTIONS**

- ☐ Group Term Life ☐ Short Term Disability ☐ Long Term Disability ☐ Voluntary Short Term Disability ☐ Voluntary Long Term Disability ☐ Voluntary Life ☐ Voluntary High Limit AD&D

All Group Life and Disability insurance products referenced as an "AXA" product shown on this enrollment form are issued exclusively by MONY America. This is not a Blue Cross and Blue Shield of Louisiana products. AXA is not affiliated with Blue Cross and Blue Shield of Louisiana. AXA is solely responsible for its insurance and claims paying obligations.

SECTION B - EMPLOYEE INFORMATION

| | | | | | | | |
|--|---|--------------|-----------------------|------------------------|------------------|------------|------------------------|
| Enrollee's Last Name | First | MI | Sex (M/F) | Birthdate (MM/DD/YYYY) | Hire Date | Job Title | Social Security Number |
| Physical Address | | City | State | Zip Code | Telephone Number | | Email Address |
| Mailing Address | | City | State | Zip Code | Fax Number | | Annual Salary |
| Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other | Retired from Current Employer <input type="checkbox"/> Yes <input type="checkbox"/> No | Date Retired | Current Employer Name | | | Home Phone | Work Phone |

SECTION C-1 - BCBSLA, HMO AND SNL ENROLLMENT EVENTS

ENROLLMENT: Requested Effective Date ____/____/____ Group # _____ ☐ New ☐ Late ☐ Rehire ☐ Special Enrollee (Go to Qualifying Event Section below.) ☐ Open Enrollment

Class (Select One): ☐ Active ☐ Management ☐ Non-Management ☐ Retiree ☐ Other _____

I am enrolling for the following BCBSLA/SNL benefits. Please check all that apply. Benefit options are dependent upon employer elections.

| | Medical | Dental | Vision | Group Life | STD | LTD | Voluntary Life | Company Use Only | Vol STD | Vol LTD | Vol High Limit & AD&D | Company Use Only |
|----------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|----------------------|---|---|-----------------------------------|----------------------|
| Employee (EE) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> \$ _____ (salary) <input type="checkbox"/> _____ | EU _____ CL _____ | \$ <input type="checkbox"/> Benefit Max | \$ <input type="checkbox"/> Benefit Max | <input type="checkbox"/> \$ _____ | EU _____ CL _____ |
| Spouse (SP) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | <input type="checkbox"/> Spouse coverage \$ _____ | EU _____ CL _____ | | | | |
| Dependent Child(ren) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | <input type="checkbox"/> Child(ren) | | | | | |
| Family | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | <input type="checkbox"/> | |
| I Decline | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

***NOTICE FOR ENROLLEES ON HMO PLANS THAT DO NOT CONTAIN A POINT-OF-SERVICE BENEFIT: YOU MUST PERSONALLY BEAR ALL COSTS IF YOU UTILIZE HEALTH CARE NOT AUTHORIZED BY THIS PLAN OR PURCHASE DRUGS WHICH ARE NOT AUTHORIZED BY THIS PLAN, WHEN THOSE HEALTH CARE SERVICES AND DRUGS REQUIRE AN AUTHORIZATION BY THE PLAN**

01MK5336 R01/18
Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company. HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc. are subsidiaries of Blue Cross and Blue Shield of Louisiana. All three companies are independent licensees of the Blue Cross and Blue Shield Association.
***"AXA" is the brand name of AXA Equitable Financial Services, LLC and its family of companies, including AXA Equitable Life Insurance Company (AXA Equitable) located at 1290 Avenue of the Americas, New York, NY 10104 and MONY Life Insurance Company of America (MONY America) located at 2999 North 44th Street, Suite 250, Phoenix, Arizona 85018. References herein to the "Company" or "AXA" refer to MONY America as the applicable issuing company.

Enrollee's Last Name _____ First Name _____ Subscriber Number _____ Group Number/Subgroup _____

SECTION C-2 - AXA - LIFE AND DISABILITY ENROLLMENT EVENTS

I am enrolling for the following AXA benefits. Please check all that apply for MONY America products. Benefit options are dependent upon employer elections.

| | AXA Group Life | AXA STD | AXA LTD | AXA Voluntary Life | Company Use Only | AXA Vol STD | AXA Vol LTD | AXA Vol High Limit & AD&D | Company Use Only |
|----------------------|--------------------------|--------------------------|--------------------------|--|--------------------------|---|---|-----------------------------------|--------------------------|
| Employee (EE) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> \$ _____ (salary) <input type="checkbox"/> _____ | EU _____ CL _____ | \$ <input type="checkbox"/> Benefit Max | \$ <input type="checkbox"/> Benefit Max | <input type="checkbox"/> \$ _____ | EU _____ CL _____ |
| Spouse (SP) | | | | <input type="checkbox"/> Spouse coverage \$ _____ | EU _____ CL _____ | | | | |
| Dependent Child(ren) | | | | <input type="checkbox"/> Child(ren) | | | | | |
| Family | <input type="checkbox"/> | | | | | | | <input type="checkbox"/> | |
| I Decline | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

SECTION C-3 - ENROLLMENT EVENTS CONTINUED

WAIVER OF MEDICAL COVERAGE I decline to enroll for this coverage due to:

☐ Spouse's Group Employer Plan Plan Name _____ Policy Number _____ ☐ COBRA from Prior Employer ☐ Tri-Care ☐ Retiree from Prior Employer
☐ BCBSLA Individual Plan ☐ Medicare ☐ Medicaid ☐ VA Eligibility ☐ Other _____ Note: If waiving all coverages, please go to Section J, read and sign.

WAIVER OF DENTAL COVERAGE

ELSEWHERE CREDIT FOR DENTAL COVERAGE I decline to enroll for this coverage due to:

☐ Waive ☐ Spouse's Group Employer Plan Plan Name _____ Policy Number _____
☐ Note: If waiving all coverages, please go to Section J, read and sign. ☐ BCBSLA Individual Plan ☐ Medicaid ☐ Tri-Care ☐ Parental Coverage (Employees under age 26)

CHANGE (Please complete Section D): Requested Effective Date ____/____/____

Type of Change: ☐ Name ☐ Address ☐ Add Dependent ☐ Subgroup ☐ Class ☐ Salary Change ☐ Qualifying Event (Complete next section)

Qualifying Event: ☐ Marriage ☐ Birth ☐ Adoption ☐ Placement for Adoption ☐ Provisional Custody by Mandate ☐ Qualified Medical Child Support Order Date of Qualifying Event ____/____/____

If you lost other coverage due to: ☐ Divorce ☐ Death ☐ Termination or reduction in work hours ☐ Employer contributions for coverage ended
(Please complete Section G) ☐ Other _____ ☐ COBRA or other continuation coverage exhausted

SECTION D - CHANGE INFORMATION (TO BE COMPLETED BY THE EMPLOYER)

The information below must be completed by the Employer if an employee is making a change.

Product Selection Change _____ Subgroup Change: Move from _____ Move to _____

Annual Salary Change from \$ _____ to \$ _____

Class Change from _____ to: _____

Employer Name _____ Employer Signature _____ Date ____/____/____

SECTION E - FAMILY MEMBERS TO BE ENROLLED OR CHANGED

| Enroll or Change (Please circle the appropriate answer) | Dependent's Full Name (Last, First, MI) | EMAIL* | RELATIONSHIP (If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.) | Birthdate Mo Day Yr | Social Security Number | Lives with You? If "No" Give Address/Location** | Mentally or Physically Incapacitated*** | Out of Area Dependent/Student |
|--|--|--------|---|------------------------|------------------------|---|---|---|
| E C | | | <input type="checkbox"/> Husband <input type="checkbox"/> Wife | | | N/A | N/A | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| E C | | | <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| E C | | | <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| E C | | | <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

SECTION E - FAMILY MEMBERS TO BE ENROLLED OR CHANGED (Continued)

| Enroll or Change (Please circle the appropriate answer) | Dependent's Full Name (Last, First, MI) | EMAIL* | RELATIONSHIP (If Dependent is not your natural child, attach documentation of legal custody or adoption. If coverage is court ordered, attach a copy of the order.) | Birthdate Mo Day Yr | Social Security Number | Lives with You? If "No" Give Address/ location** | Mentally or Physically Incapacitated*** | Out of Area Dependent/ Student |
|--|---|--------|---|------------------------|------------------------|--|---|---|
| E C | | | <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| E C | | | <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter <input type="checkbox"/> Other _____ | | | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

*Email addresses are being collected to enable our Companies to communicate with you electronically. Once enrolled for coverage, you will be able to manage your communication preferences. Minors will not receive electronic communications directly, however, if contact information for a legally responsible party is provided for a minor, that individual may receive electronic communications on behalf of the minor.

**Address/Location _____

***If your dependent is mentally or physically incapacitated, please provide the following medical documentation from your doctor: • Diagnosis of condition(s) causing incapacitation • Anticipated length of incapacitation

SECTION F - LIFE INSURANCE BENEFICIARY INFORMATION

Your employer will provide you with the opportunity to elect a beneficiary or beneficiaries on a separate beneficiary designation form or system.

SECTION G - OTHER COVERAGE OR PRIOR COVERAGE INFORMATION

| Do you or any Dependents have other Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Group? <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes to either give: | Policyholder | Insurance Company |
|---|--|---------------------------|----------------------|---|
| If more than one prior carrier, please provide a certificate of coverage from other carrier(s). | List Members Covered | Coverage Start Date | Coverage End Date | Prior Insurance Carrier and Policy Number |
| | | | | Type of Coverage (Refer to Instruction Page) |
| | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit |
| | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit |
| | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit |
| | | | | <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Limited Benefit |

| Are you or any of your dependents covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No | Name | Reason | Covered by: | Dates Medicare became effective | Medicare Numbers |
|---|------|--|--|--|--|
| If yes, complete the information on the right. Please provide a clear copy of the Medicare card. | | <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D | A. ____/____/____ B. ____/____/____ C. ____/____/____ D. ____/____/____ | A. ____ B. ____ C. ____ D. ____ |
| | | <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Part D | A. ____/____/____ B. ____/____/____ C. ____/____/____ D. ____/____/____ | A. ____ B. ____ C. ____ D. ____ |

(Continue to next page)

Enrollee's Last Name _____ First Name _____ Subscriber Number _____ Group Number/Subgroup _____

| Are you or any of your Dependents currently receiving disability benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | Name | Date of Injury/Illness / / | Reason for Disability |
|--|------|-------------------------------|-----------------------|
| If yes, complete the information on the right. | | / / | |
| | | / / | |
| | | / / | |

| Are you or any of your Dependents currently receiving workers' comp benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | Name | Date of Injury/Illness / / | Worker's Compensation Carrier Name |
|---|------|-------------------------------|------------------------------------|
| If yes, complete the information on the right. | | / / | |
| | | / / | |
| | | / / | |

SECTION H-1 - BCBSLA, HMO and SNL MEDICAL HISTORY

Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana Inc. (HMOLA), and/or Southern National Life Insurance Company, Inc. (SNLIC) in connection with the enrollment form may be retained by BCBSLA, HMOLA and/or SNLIC and used or disclosed in connection with future underwriting/renewal efforts.

IMPORTANT! FOR EACH "YES" RESPONSE, PROVIDE DETAILS ON PAGE 5

- **For Life and Disability Coverage:** If applying only for life and disability coverage as a late enrollee or for a benefit above the guarantee issue amount, you are required to answer all medical questions below. If you answer "Yes" to questions 1-5; provide details on page 5.
- **For Medical Coverage:** Medical questions are required for late enrollees on large groups as defined by the Affordable Care Act. Contact your Human Resources department if you are unsure of your group size.

Your Height* _____ Your Weight* _____ Spouse's Height* _____ Spouse's Weight* _____

Has anyone applying for coverage ever had or been diagnosed with the following conditions or do the questions below apply:

| | |
|---|---|
| 1. Abnormal blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Asthma, bronchitis or chronic sinus trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Any back and/or orthopedic condition or muscular diseases, back pain or joint pain? <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Arthritis, rheumatism/bursitis or sciatica? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Abdominal pain, ulcers, stomach, colon or other intestinal disorders, adhesions? <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Any tumors, cysts or growths? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Alcohol or substance abuse, detoxification? <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Kidneys stones or urinary system disorders, diabetes insipidus or prostate disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Are you presently taking medications? <input type="checkbox"/> Yes <input type="checkbox"/> No | 18. A mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Diabetes mellitus? <input type="checkbox"/> Yes <input type="checkbox"/> No | 19. Are you expecting a biological child within the next 9 months (male or female applicant)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Any type of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No | 20. Have you or anyone on this application, used tobacco in any form within the last 6 months including electronic cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Any blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | 21. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials or hazardous wastes or materials? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. A stroke (CVA), circulatory problems or heart trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 10. Epilepsy, seizures, fainting spells or migraines? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 11. Lung problems or tuberculosis? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 12. HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| 13. Hepatitis or any liver disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

SECTION H-2 - AXA MEDICAL HISTORY

If applying for AXA Life Insurance Company of America Life or Disability products and a medical questionnaire is required, please complete AXA's EO1 forms. The Life EO1 form number is ICC15EB15E001. The Disability EO1 form number is EB15E01D1.

Enrollee's Last Name _____ First Name _____ (Subscriber Number _____ Group Number/Subgroup _____)

IF APPLYING FOR LIFE OR DISABILITY, PROVIDE DETAILS IF YOU ANSWERED "YES" TO QUESTIONS 1-5

| Question # | Person | Condition/Diagnosis | Treatment/Complications | Dates Treated | Medications, Frequency, Dosage |
|------------|--------|---------------------|-------------------------|---------------|--------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

SECTION I - PRIMARY CARE PHYSICIAN (PCP) SELECTION - Recommended for all products. It is required for Community Blue, BlueConnect, BlueConnect Savings Plus, Signature Blue, HMO and POS products. If you do not select a PCP, one will be selected for you.*

| Enrollee Name | Social Security Number | Physician Name | Physician Address |
|---------------|------------------------|----------------|-------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

***ASO/self-funded and non-standard large fully insured group employees: a PCP may be selected for you. Check with your group leader.**

SECTION J - AXA Fraud Statements

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, New Mexico, Rhode Island, and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Maine, Tennessee, Virginia and Washington: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with an intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Ohio: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement that is material to the interests of an insurer may be guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (\$5,000) dollars and not more than ten thousand (\$10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

All Other States: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SECTION K: COVERAGE CONDITIONS**Section K-1: BCBSLA AND SNL COVERAGE CONDITIONS**

1. I, the undersigned, do hereby enroll for coverage with Blue Cross and Blue Shield of Louisiana (BCBSLA), HMO Louisiana, Inc. (HMOLA) and/or Southern National Life Insurance Company, Inc. (SNLIC) for myself and any family members listed on this enrollment form. I understand that this enrollment/change form, together with the certificate of coverage, any riders and endorsements issued by Companies, constitute my only agreement with Companies. I understand that the contract as it pertains to me and my dependent(s) will be terminated within three years of the original effective date of coverage and all fees, less claims paid, will be refunded if I committed fraud or made an intentional misrepresentation of material fact in this enrollment/change form. I further understand that if enrolled for coverage with Blue Cross and Blue Shield of Louisiana, HMO Louisiana, Inc. or Southern National Life Insurance Company, Inc. that the contract issued by either company constitutes a contract solely between that company and the group/policy holder and that Blue Cross Blue Shield of Louisiana, HMO Louisiana, Inc. and Southern National Life Insurance Company, Inc. are all independent corporations operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, the "Association" permitting the individual companies to use the Blue Cross and BlueShield service marks in the state of Louisiana and that the companies are not contracting as an agent of the Association.
2. I authorize any employer having information available as to employment, or other insurance coverage, regarding me or other family members proposed for coverage(s), to give the information to Companies or any agent acting on Companies' behalf. I understand this information will be used by the companies to determine eligibility or other related decisions deemed necessary for insurance coverage. I agree that a photographic copy of this authorization is as valid as the original. I hereby request the health coverage provided from time to time by my employer's group health plans, and I authorize deduction from my pay the amounts, if any, as may be necessary. The information given on this application is true and correct to the best of my knowledge and belief.
3. I understand that if I am declining enrollment for myself or my Dependents (including spouse), I may in the future be able to enroll myself or my Dependents in these plans, provided that I request enrollment within 30 days of the qualifying event. In addition, if I have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, I may be eligible to enroll myself or my Dependents provided that I request enrollment within 30 days after the marriage, birth adoption or placement for adoption.
4. I acknowledge if I am eligible for Medicare, by reason of age, I have received a copy of "The Guide to Health Insurance For People With Medicare."
5. IT IS A DEPENDENT'S RESPONSIBILITY TO APPLY FOR CONTINUOUS COVERAGE ON A SEPARATE CONTRACT/CERTIFICATE WHEN ELIGIBILITY CEASES.
6. FRAUD STATEMENT - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
7. All of the questions in this application and in the health history section have been read by or to me and the answers provided by the enrollee and/or Dependent(s) if any, are true and correct to the best of my knowledge and belief.

Section K-2: AXA COVERAGE CONDITIONS

"AXA" is the brand name of AXA Equitable Financial Services, LLC and its family of companies, including AXA Equitable Life Insurance Company (AXA Equitable) located at 1290 Avenue of the Americas, New York, NY 10104 and MONY Life Insurance Company of America (MONY America) located at 2999 North 44th Street, Suite 250, Phoenix, Arizona 85018. References herein to the "Company" refer to either AXA Equitable or MONY America as the applicable issuing company.

SECTION L: BCBSLA AND SNL FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X

Enrollee's Signature

Date

Enrollee's Signature Date

STOP

Have you selected a PCP? Recommended for all products. It is required for Community Blue, BlueConnect, BlueConnect Savings Plus, Signature Blue, HMO and POS products.*

*ASO/self-funded and non-standard large fully insured group employees: a PCP may be selected for you. Check with your group leader.

| | | | |
|----------------------------|-----------------------|-------------------|--|
| OFFICE USE ONLY | HEALTH EFFECTIVE DATE | LW INT. HLTH. DT. | |
| | DENTAL | VISION | OUT OF ELIG.? <input type="checkbox"/> YES <input type="checkbox"/> NO |

Attach additional pages if necessary



**BlueCross BlueShield
of Louisiana**

Post Office Box 98029
Baton Rouge, Louisiana 70898-9029

**CONTINUATION OF
COVERAGE UNDER COBRA
OR STATE GROUP**

An independent licensee of the Blue Cross and Blue Shield Association.

U1 _____ 02 _____ 03 _____ 04 _____

THIS FORM IS TO BE COMPLETED BY THE EMPLOYER AND RETURNED TO:

Blue Cross and Blue Shield of Louisiana
Attn: Membership and Billing Department
P.O. Box 98029
Baton Rouge, LA 70898-9029

For COBRA Continuation a completed and signed application for the **continuing** spouse or child must be returned to us along with this continuation of coverage form. An application is not necessary for employees continuing because of termination of employment or reduction in hours.

For State Continuation, an application for the surviving spouse must be completed, signed, dated and returned with this Continuation of Coverage form within 90 days of the employee's death. The Guidelines for State Continuation are on the other side of this form.

| EMPLOYER INFORMATION | | | |
|----------------------|------|------------------|----------|
| NAME OF GROUP | | GROUP POLICY NO. | |
| ADDRESS | CITY | STATE | ZIP CODE |

REASON(S) FOR GROUP COVERAGE ENDING

- ☐ death of the covered employee
- ☐ termination of employment of the covered employee (other than by reason of the employee's gross misconduct) or reduction in hours
- ☐ the divorce or legal separation of the covered employee from the employee's spouse
- ☐ the covered employee's commencement of Medicare coverage
- ☐ the end of dependent child coverage under the terms of the plan
- ☐ employee leaving employment due to disability

| | | | |
|---|------|---------------------------|----------|
| NAME OF CONTINUING EMPLOYEE, SPOUSE OR CHILD | | SOCIAL SECURITY NUMBER | |
| RELATIONSHIP OF CONTINUING PERSON TO EMPLOYEE | | DATE OF BIRTH | |
| EMPLOYEE NAME | | DATE GROUP COVERAGE ENDED | |
| EMPLOYEE'S ADDRESS | CITY | STATE | ZIP CODE |
| DATE OF EMPLOYEE'S DEATH, IF APPLICABLE | | CONTRACT NUMBER | |

- ☐ I hereby waive my right for COBRA continuation of coverage under this plan.

EMPLOYEE/DEPENDENT(S) SIGNATURE

DATE

EMPLOYER SIGNATURE

DATE

CONTINUATION OF COVERAGE UNDER COBRA OR STATE CONTINUATION

**THIS FORM IS TO BE
COMPLETED BY THE
EMPLOYER AND
RETURNED TO:**

Blue Cross and Blue Shield of Louisiana
Attn: Membership and Billing Department
P.O. Box 98029
Baton Rouge, LA 70898-9029
Fax Number: 225-298-2988

A completed and signed application for the **continuing** spouse or dependent must be returned to us along with this continuation of coverage form. An application is not necessary for employees continuing because of termination of employment or reduction in hours.

For State Continuation, for the surviving spouse age 50 years and older, an application must be completed, signed, dated and returned with the Continuation of Coverage form within 90 days of the employee's death.

| EMPLOYER INFORMATION | | | |
|----------------------|------|------------------|----------|
| NAME OF GROUP | | GROUP POLICY NO. | |
| ADDRESS | CITY | STATE | ZIP CODE |

REASON(S) FOR GROUP COVERAGE ENDING

- ☐ death of the covered employee
- ☐ termination of employment of the covered employee
- ☐ divorce of the covered employee from the employee's spouse
- ☐ reduction in employment hours (COBRA reason only)
- ☐ the covered employee's commencement of Medicare coverage (COBRA reason only)
- ☐ the end of dependent child coverage under the terms of the plan (COBRA reason only)
- ☐ employee leaving employment due to disability (COBRA reason only)

| | | | |
|--|------|---------------------------|----------|
| NAME OF CONTINUING EMPLOYEE, SPOUSE OR DEPENDENT | | SOCIAL SECURITY NUMBER | |
| RELATIONSHIP OF CONTINUING PERSON TO EMPLOYEE | | DATE OF BIRTH | |
| EMPLOYEE NAME | | DATE GROUP COVERAGE ENDED | |
| EMPLOYEE'S ADDRESS | CITY | STATE | ZIP CODE |
| DATE OF EMPLOYEE'S DEATH, OR DIVORCE DECREE DATE | | CONTRACT NUMBER | |

Note: Please refer to your Continuation of Coverage Rights Provision Section of your policy booklet.

If applying for COBRA, coverage is limited to a maximum of 18 months. If applying for state continuation, coverage is limited to a maximum of 12 months.

EMPLOYEE/DEPENDENT(S) SIGNATURE

DATE

EMPLOYER SIGNATURE

DATE

GUIDELINES FOR STATE CONTINUATION OF GROUP COVERAGE

- I. Upon the Employee's death, a surviving spouse covered as Dependent, who is 50 years of age and older has 90 days:
- of continued coverage for himself/herself, and if already covered, for his/her Dependent children;
 - to elect to further continue that same coverage, on a premium-paying basis without a physical exam.

- II. If the continuation is not chosen, insurance coverage ceases at the end of the 90-day period. If the continuation is chosen:
- coverage is effective retroactive to the date the Employee's insurance terminated; and
 - premium is due from the surviving spouse from the last date for which the premium has been paid.

Premium will not exceed the premium assessed for each Employee by class of coverage under the group Contract.

- III. The Employer will be responsible:

- for notifying the surviving spouse of the right to continue; and
- for billing and collection of premium.

However, if Blue Cross and Blue Shield of Louisiana has been furnished with the home address of the surviving spouse at the time of the employee's death and has been notified in a manner acceptable to it of the death of the Employee by the Employer, Blue Cross and Blue Shield of Louisiana will notify the surviving spouse of the right to continue.

- IV. Coverage continued on a premium paying bases terminates on the earliest of:

- the date the premium is not paid;
- the date the surviving spouse or Dependent children become eligible for Medicare;
- the date the surviving spouse or Dependent children become eligible for coverage on another group health plan;
- the date the surviving spouse remarries, or dies;
- the date the group Contract ends; or
- the date the Dependent child is no longer eligible.

- V. If the surviving spouse has continued coverage under both an individual policy; and the group Contract:

Blue Cross and Blue Shield of Louisiana will pay benefits under either the individual conversion policy or the group Contract, but not both. Benefits under the group Contract will be paid upon surrender of the individual policy with no claim, other than a return of premium less any debt. If the individual policy is not surrendered, benefits will be paid under it but not under the group Contract.



Blue Cross and Blue Shield of Louisiana
HMO Louisiana
Southern National Life

COVERAGE CANCELLATION

| | | | |
|---|---|--|--|
| GROUP NAME | | | GROUP NUMBER |
| EMPLOYEE'S NAME | | | CONTRACT NUMBER |
| EMPLOYEE'S ADDRESS | | | SOCIAL SECURITY NUMBER |
| LAST DATE OF EMPLOYMENT | DATE OF DEATH | LAST DATE OF COVERAGE | REASON FOR CANCELLATION |
| PLEASE CHECK ALL THAT APPLY: | | | |
| <input type="checkbox"/> Cancel/Terminate ENTIRE CONTRACT (all BCBSLA, HMO LA, and SNL products will be cancelled) | | | |
| <input type="checkbox"/> Cancel/Terminate EMPLOYEE PRODUCT(S) (select which BCBSLA, HMO LA, and/or SNL products below to be cancelled) | | | |
| <input type="checkbox"/> Medical | <input type="checkbox"/> *Group Term Life/AD&D | <input type="checkbox"/> **Voluntary Group Term Life/AD&D | <input type="checkbox"/> Voluntary Short Term Disability |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Dependent Life only | <input type="checkbox"/> Voluntary Spouse Life only | <input type="checkbox"/> Voluntary Long Term Disability |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Short Term Disability only | <input type="checkbox"/> Voluntary Child Life only | <input type="checkbox"/> Voluntary High Limit AD&D |
| <input type="checkbox"/> Cancel/Terminate DEPENDENT(S) (complete the next section) | | | |
| COMPLETE THE FOLLOWING SECTION FOR CANCELLATION OF DEPENDENT COVERAGE: | | | |
| SPOUSE'S NAME | RELATIONSHIP | Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Voluntary Spouse Life | |
| DEPENDENT'S NAME | RELATIONSHIP | Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision | |
| DEPENDENT'S NAME | RELATIONSHIP | Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision | |
| DEPENDENT'S NAME | RELATIONSHIP | Products: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision | |

*Terminating Group Term Life/AD&D will automatically terminate Dependent Life and Short Term Disability

**Terminating Voluntary Group Term Life/AD&D will automatically terminate Voluntary Spouse Life and Voluntary Child Life

X

EMPLOYEE SIGNATURE

DATE

By submitting a request to cancel any individual's coverage on this form, the Group/Employer/Company states:

- That neither the Member nor his/her dependent being cancelled has made payment towards the cost of premiums for any period beyond the date the group is requesting the coverage to be terminated. Excepted are employee contributions towards the cost of family coverage when termination of a dependent does not affect the total cost of the employee premium for a period after the date the cancellation is being requested.
- That no information was provided or representation made to the member or his/her dependent being cancelled that would create an expectation that the individual's coverage would continue beyond the date of the requested coverage termination, except for legally required disclosures regarding rights to COBRA or other mandated form of continuation coverage.

The group understands that both of these statements have to be met in order to cancel any individual's coverage pursuant to the Patient Protection and Affordable Care Act's (PPACA) prohibition on rescissions, and agrees to hold the health insurer harmless for any consequence related, directly or indirectly, to the falsity or inaccuracy of any of these statements. The group further understands that an individual may have a right to contest the cancellation of his/her coverage under the law, and that cancellations of coverage determined to have been made against the law under an internal and/or external review procedure, or order from an administrative agency or court, may require the reinstatement of the individual's coverage or the modification of the individual's cancellation date. In such event, the group will be responsible to pay the corresponding premiums for the individual's coverage, along with any other indemnifications, fines, penalties or other legal remedies, including attorney fees and costs, in which might have been incurred by or imposed upon the health insurer under that procedure.

X

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE GROUP

DATE

Please fax this form to (225) 298-2988 or mail to:

Blue Cross and Blue Shield of Louisiana
Attention: Membership and Billing Department
P. O. Box 98029
Baton Rouge, LA 70898-9029

Client: _____ **FEIN:** _____
 (Federal Employer Identification Number)

Qualified Beneficiary Name: _____ **SSN:** _____
 (Or Alternate ID)

Address: _____ **City:** _____ **St:** _____ **Zip:** _____

Date of Birth: ____ / ____ / ____ **Sex:** ☐ Male ☐ Female **Date of Hire:** ____ / ____ / ____

Waiting Period Begin Date ____ / ____ / ____ **Coverage Begin Date:** ____ / ____ / ____

Relationship to Former Employee: ☐ Self ☐ Spouse ☐ Child **Monthly Flexible Spending Amount:** \$ ____ .00

Employee SSN ____ - ____ - ____ **Name:** _____
 (Or Alternate ID) (Federal Employer Identification Number)

Division/Location: _____ **Election Notice Mailed Date:** ____ / ____ / ____

Qualifying Event Date: ____ / ____ / ____ **Last Day of Pre-COBRA Coverage:** ____ / ____ / ____

Reason for Qualifying Event: (check only one)

- | | | |
|--|--|---|
| <u>18 Month Coverage Continuation</u> | <u>29 Month Coverage Continuation (11 month extension)</u> | <u>36 Month Coverage Continuation</u> |
| <input type="checkbox"/> 02 Employee's Resignation | <input type="checkbox"/> 16 Disability Extension | <input type="checkbox"/> 14 Death of the Covered Employee |
| <input type="checkbox"/> 03 Employee's Involuntary Termination | | <input type="checkbox"/> 11 Divorce/Legal Separation |
| <input type="checkbox"/> 04 Reduction in Hours | | <input type="checkbox"/> 13 Employee's Medicare Eligibility |
| <input type="checkbox"/> 05 Layoff | | <input type="checkbox"/> 12 Loss of Dependent Eligibility |
| <input type="checkbox"/> 15 Bankruptcy | | |

Current Coverage:

Provide the Plan Name and indicate which Coverage(s) the above named continuant has current coverage for.
 (Check the appropriate space below.)

| Plan Name | Employee Only | Spouse Only | Child Only | Spouse + Child(ren) | Children Only | Employee + Spouse | Employee + Child(ren) | Family |
|-----------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

List Dependent(s) Losing Coverage:

Please provide Dependent(s) mailing address on separate sheet if different than Continuant's mailing address.

| Name (last, first) | SSN | DOB | Coverage Start Date | Relation to Employee | Student Y/N |
|--------------------|-----|-----|---------------------|----------------------|-------------|
| , | - - | / / | / / | | |
| , | - - | / / | / / | | |
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| , | - - | / / | / / | | |
| , | - - | / / | / / | | |



BlueCross BlueShield
of Louisiana

An Independent Licensee of the Blue Cross and Blue Shield Association.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS ON BACK BEFORE
COMPLETING OR SIGNING THIS FORM

MAIL COMPLETED CLAIMS TO:

BLUE CROSS AND BLUE SHIELD
OF LOUISIANA
CLAIMS PROCESSING
P.O. BOX 98029
BATON ROUGE, LA 70898-9029

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

| PLEASE PRINT OR TYPE | | ONLY ONE PATIENT PER CLAIM FORM | | 1. SUBSCRIBER'S BLUE CROSS AND BLUE SHIELD CONTRACT NO. | |
|---|-------------------------------|---|--|--|-------------------------------|
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/> | | 4. SUBSCRIBER'S NAME (Last Name, First Name, Middle Initial) | |
| 5. PATIENT'S ADDRESS (Street Number) | | 6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | 7. SUBSCRIBER'S ADDRESS (Street Number) | |
| CITY | STATE | 8. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE ITEM 9. | | CITY | STATE |
| ZIP CODE | TELEPHONE (Include Area Code) | | | ZIP CODE | TELEPHONE (Include Area Code) |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO | | <input type="checkbox"/> CHECK IF THIS IS A NEW ADDRESS | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO | | 11. SUBSCRIBER'S POLICY GROUP NO. OR GROUP NAME | |
| b. OTHER HEALTH INSURANCE COVERAGE NAME AND ADDRESS | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | a. SUBSCRIBER'S DATE OF BIRTH MM DD YY | |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | | c. OTHER ACCIDENT OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO | | b. SUBSCRIBER'S SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| | | d. DATE OF ACCIDENT OR INJURY? | | RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| | | | | c. INSURANCE PLAN NAME OR PROGRAM NAME | |

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

12. FOR OFFICE USE ONLY

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.

X

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION (ONLY ONE PHYSICIAN PER CLAIM FORM)

| | | | | | |
|---|--|--|---------------------------|---|---------------------|
| 14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY | | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY | | | |
| 16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | | 17. I.D. NUMBER OF REFERRING PHYSICIAN | | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM TO | |
| 19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 20E BY 1. _____ 3. _____ 2. _____ 4. _____ | | | | | |
| 20. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY | | B.* Place of Service | C.* Type of Service | D. PROCEDURES, SERVICES OR SUPPLIES CPT HCPCS MODIFIER | E. DIAGNOSIS CODE |
| | | | | | |
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| | | | | | |
| 21. FEDERAL TAX I.D. NUMBER | | SSN <input type="checkbox"/> EIN <input type="checkbox"/> | 22. PATIENT'S ACCOUNT NO. | | 23. TOTAL CHARGE \$ |
| | | | | | 24. AMOUNT PAID \$ |
| | | | | | 25. BALANCE DUE \$ |
| 26. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof) | | 27. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office) | | 29. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # | |
| | | | | | |
| SIGNED | | DATE | | PIN # GRP # | |

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON BACK REMARKS

23XX6537 R03/04

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Services & Indemnity Company

HOW TO FILE A CLAIM

Items 1 through 12 of the top portion of the claim form must be filled out by you. The doctor, hospital or other supplier may complete the bottom portion of the form; or you may attach a copy of an itemized bill of the charges from the doctor or supplier. A sample of the part that you must complete is shown below.

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

| PLEASE PRINT OR TYPE | | ONLY ONE PATIENT PER CLAIM FORM | | 1. SUBSCRIBER'S BLUE CROSS AND BLUE SHIELD CONTRACT NO. | |
|--|--|---|--|---|--|
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial) | | 3. PATIENT'S BIRTH DATE MM DD YY | | 4. SUBSCRIBER'S NAME (Last Name, First Name, Middle Initial) | |
| 5. PATIENT'S ADDRESS (Street Number) | | 6. PATIENT RELATIONSHIP TO INSURED <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other | | 7. SUBSCRIBER'S ADDRESS (Street Number) | |
| CITY | | STATE | | CITY | |
| ZIP CODE | | TELEPHONE (Include Area Code) | | ZIP CODE | |
| 8. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, COMPLETE ITEM 9. | | 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | | 10. IS PATIENT'S CONDITION RELATED TO <input type="checkbox"/> CHECK IF THIS IS A NEW ADDRESS | |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | | a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO | | 11. SUBSCRIBER'S POLICY GROUP NO. OR GROUP NAME | |
| b. OTHER HEALTH INSURANCE COVERAGE NAME AND ADDRESS | | b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO | | a. SUBSCRIBER'S DATE OF BIRTH MM DD YY | |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | | c. OTHER ACCIDENT OR INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO | | b. SUBSCRIBER'S SEX M <input type="checkbox"/> F <input type="checkbox"/> | |
| | | d. DATE OF ACCIDENT OR INJURY? | | c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW. | | | | | |
| 12. FOR OFFICE USE ONLY | | | | 13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. | |
| | | | | X PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | |

INSTRUCTIONS

1. **Subscriber's Blue Cross and Blue Shield Contract Number** - Please fill in the insured's contract number exactly as shown on the insured's Blue Cross and Blue Shield Identification card. You should double check this number to be sure it is correct.
2. **Patient's Name** - Please fill in the patient's name as it appears on the insured's Blue Cross and Blue Shield application.
3. **Patient's Birth Date** - Please enter month, day, year and check male or female. For example: May 21, 1958 would be 5/21/58.
4. **Subscriber's Name** - Please fill in the insured's name as it appears on the Blue Cross and Blue Shield Identification card.
5. **Patient's Address** - Please fill in the patient's complete mailing address and correct telephone number.
6. **Patient Relationship to Insured** - Please check the block that indicates how the patient is related to the insured.
7. **Subscriber's Address** - Please enter the complete mailing address and telephone number of the Blue Cross and Blue Shield policyholder. If this information was already entered in item 5, then you may enter "same." If this is a new address, please check the box provided.
8. **Is there another Health Benefit Plan?** - If the patient is covered by another group health policy, check the "yes" block and answer item 9.
9. **Other Insured's** - If the patient is covered by another group health policy through an employer or by Medicare, please fill in the policyholder's name.
 - a. Other Insured's Policy or Group Number - Please fill in the policy number used by the other insurance coverage.
 - b. Other Health Insurance Coverage Name and Address - Please enter the name and address used by the other insurance company.
 - c. Insurance Plan Name - Please enter the plan or program name used by the other insurance company.
10. **Is Patient's Condition Related To** -
 - a. Employment (Current or Previous) - Check yes or no.
 - b. Auto Accident - Check yes or no.
 - c. Other Accident or Injury - Check yes or no.
 - d. Date of Accident or Injury - If a "Yes" block was checked in item 10, please indicate the date. Please enter month, day, year.
11. **Subscriber's Policy Group Number or Group Name** - Please enter the Group number as shown on the insured's Blue Cross and Blue Shield Identification card. If this information is not available, please enter the name of the company that employs the insured.
 - a. Subscriber's Date of Birth - Please enter month, day and year. For example: May 27, 1956 would be 5/27/56.
 - b. Subscriber's Sex - Please indicate whether the insured is male or female and if that person is retired.
 - c. Insurance Plan Name - Please enter the plan name or program name.

PLEASE NOTE

Blocks 1 through 11 of this form MUST be completed. If blocks 14-29 are not completed, the Doctor's statement of services rendered MUST be attached to this claim form. If the attending Doctor's statement is attached, the Doctor's signature is not required in block 26 of this claim form. Please submit only one patient per claim form and only one physician per claim form.

FOR PHYSICIAN/SUPPLIER USE ONLY

PLACE OF SERVICE CODES

- | | |
|--|---|
| <ul style="list-style-type: none"> 1 - (IH) - Inpatient Hospital 2 - (OH) - Outpatient Hospital 3 - (O) - Doctor's Office 4 - (H) - Patient's Home 5 - Day Care Facility (PSY) 6 - Night Care Facility (PSY) 7 - (NH) - Nursing Home 8 - (SNF) - Skilled Nursing Facility 9 - Ambulance | <ul style="list-style-type: none"> 0 - (OL) - Other Location A - (IL) - Independent Laboratory B - (ASC) - Ambulatory Surgical Center C - (RTC) - Residential Treatment Center D - (STF) - Specialized Treatment Center E - (COR) - Comprehensive Outpatient Rehabilitation Facility F - (KDC) - Independent Kidney Disease Treatment Center |
|--|---|

TYPE OF SERVICE CODES

- | | |
|---|--|
| <ul style="list-style-type: none"> 1 - Medical Care 2 - Surgery 3 - Consultation 4 - Diagnostic X-Ray 5 - Diagnostic Laboratory 6 - Radiation Therapy 7 - Anesthesia 8 - Assistance at Surgery 9 - Other Medical Services 0 - Blood or Packed Red Cells | <ul style="list-style-type: none"> A - Used DME F - Ambulatory Surgical Center H - Hospice L - Renal Supplies in the Home M - Alternate Payment for Maintenance Dialysis N - Kidney Donor V - Pneumococcal Vaccine Y - Second Opinion on Elective Surgery Z - Third Opinion on Elective Surgery |
|---|--|

**The Society of the Roman Catholic Church
of the
Diocese of Lake Charles

Cafeteria Benefit Plan**

Election and Compensation Reduction Agreement

Name: _____ Social Security No: _____

Address: _____

On the accompanying benefit enrollment form(s), I have enrolled for certain medical benefit coverages.

I elect to receive

_____ my dependent health care insurance

_____ my (other benefits, if available)

under the Diocese's Cafeteria benefit plan. Any previous election and compensation reduction agreement under the Cafeteria Benefit Plan relating to the same benefits is hereby revoked.

I and my employer _____ agree that my regular pay will be reduced by the amount of my required contribution for the benefit option (s) I have elected under the Cafeteria Benefit Plan, effective _____* and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for each benefit option selected is set forth on a schedule that has been provided to me.

I understand that:

I cannot change or revoke this benefit election or compensation reduction agreement as of any date prior to the next July 1, unless that change or revocation is on account of and consistent with a change in my family status (i.e., my marriage or divorce, death of my spouse or dependent, birth or adoption of my child, commencement or termination of employment of my spouse, my or my spouse's unpaid leave of absence or change from full-time to part-time employment (or vice versa), a significant change in my spouse's employment or such other events as the plan administrator determines will permit a change or revocation of an election.

* The pay reduction may not be effective for any pay period that begins before you have signed this form and returned it to the plan administrator.



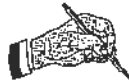
EXPRESS SCRIPTS®
Charting the Future of Pharmacy

PRESCRIPTION DRUG CLAIM FORM

BSL

| | | | |
|---|-------------------|--------------------------|----------------------|
| Cardholder's Name (Last, First, MI) | Date of Birth | Gender (circle) M F | Cardholder ID Number |
| Address <input type="checkbox"/> Check if new address | | | |
| Street _____ City _____ | | | |
| State _____ Zip Code _____ Daytime Telephone (____) _____ | | | |
| Employer | Insurance Carrier | Group Number | |

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.



Cardholder's Signature

Date

Patient Information (please list information for each patient submitting claims)

| | | | | | |
|----------------------------|----------------|--|---|---------------|------------------------------------|
| 1 | Patient's Name | Relationship to Cardholder?(circle) Self, spouse, dependant | Gender (circle) M F | Date of Birth | Total number of receipts attached: |
| Pharmacy Name and Address: | | | Physician Name (name of prescribing Doctor) and DEA#: | | |
| 2 | Patient's Name | Relationship to Cardholder?(circle) Self, spouse, dependant | Gender (circle) M F | Date of Birth | Total number of receipts attached: |
| Pharmacy Name and Address: | | | Physician Name (name of prescribing Doctor) and DEA#: | | |
| 3 | Patient's Name | Relationship to Cardholder?(circle) Self, spouse, dependant | Gender (circle) M F | Date of Birth | Total number of receipts attached: |
| Pharmacy Name and Address: | | | Physician Name (name of prescribing Doctor) and DEA#: | | |

Prescription Information

➔ **IMPORTANT** ➔ All prescription claims must have prescription receipts/labels which include:

- Pharmacy Name/Address • Date Filled • Drug Name, Strength and NDC • Rx Number • Quantity • Days Supply
- Total Price • Patient's Name

Claims received missing any of the above information may be returned or payment may be denied or delayed

- ☒ Please tape receipts to separate piece of paper.
- ☒ Patient history print outs from the pharmacy are also acceptable but **MUST** be signed by the Pharmacist.
- ☒ **CASH REGISTER RECEIPTS ARE NOT ACCEPTABLE FOR ANY PRESCRIPTIONS.** (Except diabetic supplies)

OTHER RX COVERAGE:

Does the patient have primary prescription drug coverage through another insurance carrier? ☐ yes ☐ no. Did the patient submit this claim to the other carrier? ☐ yes ☐ no *If yes, please attach an explanation of benefits from your primary carrier or print out from the pharmacy which must include all information listed in the box above.*



Is claim for **DIABETIC SUPPLY**? ☐ yes ☐ no. If **Yes**, please provide receipt stating: Pharmacy Name/Address

• Date Filled • Type of Insulin and/or Type of supply • Quantity • Days Supply • Price • Patient's Name. Cash register receipts are acceptable but **Pharmacist Signature** is required if any information is handwritten.

*****Ask your pharmacist how you can purchase diabetic supplies with your prescription card*****

Does the patient reside in an **assisted living facility**? ☐ yes ☐ no

Is this claim for **allergy serum**? ☐ yes ☐ no

REASON FOR CLAIM SUBMISSION OR SPECIAL NOTES:

ESI USE ONLY

PLEASE READ THE FOLLOWING INSTRUCTIONS CAREFULLY AND COMPLETE FORM**Cardholder's Information (The Cardholder is the insured member whose employer provides this benefit.)**

1. Print Cardholder's name (last, first, middle initial).
2. Print Cardholder's date of birth.
3. Circle the correct letter to indicate if Cardholder is male or female.
4. Print Cardholder's ID number (found on prescription drug or Health Insurance card).
5. Print Cardholder's mailing address and telephone numbers. Check box if this is a new address.
6. Indicate Cardholder's employer, insurance carrier and group number (refer to drug card).

IMPORTANT: CLAIM FORM MUST BE SIGNED.**UNSIGNED CLAIM FORMS CANNOT BE PROCESSED AND WILL BE RETURNED.****Patient Information (Complete a section for each family member who is submitting prescriptions.)**

1. Print Patient's name.
2. Identify relationship to cardholder, gender, date of birth, and number of prescriptions submitted for each patient.
3. Print Pharmacy name and address and the prescribing Doctor and DEA number used by each patient.

Specific Claim Information: Answer each question by checking correct box. Use the space provided for special notes if necessary.

Prescription Information Each submission must include prescription receipts/labels or a patient history printout from your pharmacy, **signed** by the dispensing pharmacist, which include all information listed below:

- Pharmacy name and address
- Date filled
- Drug name, strength and NDC number
- Rx Number
- Quantity
- Days Supply
- Price
- Patient's name

(Please note that Claims received missing any of the above information may be returned or payment may be denied.)

It is preferable to have receipts unattached or taped to a separate piece of paper. *Please DO NOT staple or glue.*

Reason for claim submission or special notes: This section can be used for special notes or comments.

Questions? Call Express Scripts Customer Service Department at 1-866-781-7533

Please return this claim to: Express Scripts, Inc.
P.O. Box 66583
St. Louis, MO 63166-6583
ATTN: STD ACCTS



**BlueCross BlueShield
of Louisiana**

An Independent Licensee of the Blue Cross and Blue Shield Association.



**HMO
Louisiana, Inc.**

A subsidiary of Blue Cross and Blue Shield of Louisiana,
Independent licensees of the Blue Cross and Blue Shield Association.

AUTHORIZED DELEGATE FORM

Instructions: This form is used for you to give Blue Cross and Blue Shield of Louisiana (BCBSLA)** permission to share your protected health information with another person or company (for example, with your spouse or insurance agent). Please fill out Section C with your information and Section D, with the information on the person or company who is to get the information. You must also sign the form in Section F.

****BCBSLA** refers to Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana and its subsidiary HMO Louisiana, Inc. (collectively referred to herein as "BCBSLA")

Section A. Purpose

This form is submitted at the request of the person listed in Section C to allow BCBSLA to share that person's protected health information with those listed in Section D.

Section B: Protected Health Information to be disclosed

I give BCBSLA permission to disclose any of my personal information protected by federal or state law to the person(s) or company listed in Section D. I understand that this personal information may contain detailed medical information, except for psychotherapy notes, HIV information, or genetic information. (An additional authorization form is required to release those types of information).

SECTION C: MEMBER INFORMATION

(List the specific person whose information is to be shared, even if that person is not the policy holder.)

*Name: _____
 *Address: _____
 *City: _____ State: _____ Zip: _____
 *Member ID Number: _____ or Social Security Number: _____

Section D: Person to Receive Information

Name the person or company to whom BCBSLA may give your protected information. We must confirm the identity of the person(s) when they call, so please provide the date of birth or driver's license number of the person or the tax ID number of the company you list below.

| Person / Organization #1 | Person / Organization #2 |
|-----------------------------------|-----------------------------------|
| *Name _____ | *Name _____ |
| *Address _____ | *Address _____ |
| *City _____ State _____ Zip _____ | *City _____ State _____ Zip _____ |
| *Date of Birth / Tax ID: _____ | *Date of Birth / Tax ID: _____ |
| *Driver's License #: _____ | *Driver's License #: _____ |

*This information is required to process the form.

(over)

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

Section E: Important Information

No Conditions. BCBSLA will continue providing you with services if you do not complete this form. We will just not be able to share your information with the people you list unless this form is completed.

Further disclosure. If person(s) or company listed in Section D is not required to follow the federal health information privacy laws, they may further share your information and it may no longer be protected by the federal health information privacy laws.

Expiration. This authorization will automatically expire upon BCBSLA's knowledge that you have ended your health insurance coverage.

Right to Revoke. You may withdraw your permission to allow BCBSLA to share your information with those listed on this form by writing to the Privacy Office. Withdrawing your permission will not affect any action taken before we received your letter.

Section F: Signature

I, _____, have read and thought about the contents of this form. I agree that the information I put on this form is correct. I understand that by signing this form I am giving permission to BCBSLA to share my protected health information with those listed in Section D.

Signature: _____ **Date:** _____

If this authorization is signed by a personal representative* on behalf of the person listed in Section C, complete the following:

Personal Representative's Name _____

Relationship to the individual: _____

Attach legal documentation of guardianship or Power of Attorney. This documentation is required to process the authorization form.

*Personal representative is a legal designation and generally refers to the parent of a minor, legal guardian, or holder of Power of Attorney).

Privacy Office
5525 Reitz Avenue, Baton Rouge, LA 70809-3802
Phone: (225) 298-1751 Fax: (225) 298-1590.

Send Completed Forms to
CUSTOMER SERVICE
BLUE CROSS AND BLUE SHIELD OF LOUISIANA
P.O. BOX 98029
BATON ROUGE, LA 70898-9029
FAX (225) 297-2727 or (225) 295-2494



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and Blue Shield Association.
Post Office Box 98029 • Baton Rouge, Louisiana 70898-9029



**HMO
Louisiana, Inc.**

A subsidiary of Blue Cross and Blue Shield of Louisiana,
independent licensees of the Blue Cross and Blue Shield Association.
Post Office Box 98024 • Baton Rouge, Louisiana 70898-9024

DEPENDENT CERTIFICATION

01 _____ 02 _____ 03 _____ 04 _____

☐ **SECOND REQUEST (IF BOX IS CHECKED)**

DEPENDENT NAME

CONTRACT NUMBER

GROUP NUMBER

FOLD

1. . . . ☐ YES ☐ NO Is dependent less than 25 years old?

DATE OF BIRTH

DATE DEPENDENCY BEGAN

SEX

☐ M ☐ F

2. . . . ☐ YES ☐ NO Is dependent married? ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

3. . . . ☐ YES ☐ NO Is dependent covered under any other insurance contract? If yes, give name of company and policy number.

NAME

POLICY NO.

4. . . . ☐ YES ☐ NO Does dependent rely upon you for financial support?

5. . . . ☐ YES ☐ NO Does dependent reside with you?

IS DEPENDENT YOUR ☐ NATURAL CHILD ☐ ADOPTED CHILD

☐ CHILD FROM A PREVIOUS MARRIAGE ☐ OTHER _____

6. . . . ☐ YES ☐ NO Is dependent a full time student?

NAME AND ADDRESS OF SCHOOL NOW ATTENDING

STUDENT ID NUMBER

CURRENT
TERM

FROM _____ TO _____

EXPECTED DATE OF GRADUATION

ORIGINAL ENROLLMENT DATE

7. . . . ☐ YES ☐ NO Has dependent been a full-time student since reaching age 21?

8. . . . ☐ YES ☐ NO Is dependent mentally or physically incapacitated? If yes, please attach medical documentation from your doctor with an explanation of:

A. Diagnosis of condition(s) causing incapacitation B. Date dependent first became incapacitated
C. Anticipated length of incapacitation

9. . . . ☐ YES ☐ NO Has student dependent lost full-time status due to a medically necessary leave of absence? If yes, please read the Michelle's Law notice on back and have the physician complete the physician certification information and return within 30 days.

CERTIFICATION BY SUBSCRIBER - READ CAREFULLY - THIS SECTION MUST BE SIGNED BY SUBSCRIBER

I, _____, certify that the foregoing information is correct to the best of my knowledge, and agree to the following:
(Please print name of subscriber)

1. . . . I will inform Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. of any changes affecting the above dependent's status.

2. . . . I agree to refund to Blue Cross and Blue Shield of Louisiana or HMO Louisiana, Inc. any monies they paid on the above dependent should that dependent at any time not qualify under the above guidelines, and during that period of non-qualification they paid monies for the above dependent based on the certification and

3. . . . I authorize Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. to verify, directly or indirectly, or through its authorized agents, any of the foregoing information.

X

Date

Subscriber's Signature

OFFICE USE ONLY

UW Int.

Approved

Not Appd.

Blue Cross and Blue Shield of Louisiana Incorporated as Louisiana Health Service & Indemnity Company

24XX0205 R08/09

Thank you!



**BlueCross BlueShield
of Louisiana**

An independent licensee of the Blue Cross and Blue Shield Association.



**HMO
Louisiana, Inc.**

A subsidiary of Blue Cross and Blue Shield of Louisiana,
Independent licensees of the Blue Cross and Blue Shield Association.

MICHELLE'S LAW NOTICE

Eligibility for Continued Coverage for Dependent Students on Medically Necessary Leave of Absence

Michelle's Law applies to health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law is effective beginning January 1, 2010). Michelle's Law provides continued coverage under Blue Cross and Blue Shield of Louisiana and HMO Louisiana, Inc. health plans for dependent children who are covered under the health plan as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed during this one-year period, the plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Coordination with COBRA or State Continuation Coverage

If your child is eligible for Michelle's Law continued coverage and loses coverage under the plan at the end of the continued coverage period, continuation coverage may be available under COBRA or State Continuation at the end of Michelle's Law coverage period. If you are on a group plan, please contact your group administrator for more information.

Questions?

If you have any questions regarding the information in this notice or your child's right to Michelle's Law's continued coverage, please contact Customer Service. The number may be found on the back of your ID card.

Only complete this section if "yes" is answered to question #9 of the Dependent Certification Form.

The undersigned physician hereby certifies that _____ is suffering from a serious illness or injury and that the dependent's leave of absence (or other change in enrollment of the dependent at the school) is medically necessary.

Describe dependent's medical condition _____

Beginning date of dependent's medical leave _____

I hereby certify that the above information is true and complete.

Physician Name _____ Address _____

Phone _____ Date _____

CHECKLIST FOR CONTINUATION OF COVERAGE

The five forms that are used in the process of offering Continuation of Coverage to employees who are leaving employment are as follows:

- 1) **Group Health Insurance Continuation Coverage Letter**-This is given to the employee to explain what is available to them. They must sign and give back the last page to the Bookkeeper.
- 2) **Blue Cross Form-Continuation of Coverage Under Cobra or State Group**-This is given to the employee and must be filled out and returned to the Bookkeeper.
- 3) **Extended Health Benefits Form**-If the employee chooses to take the coverage, they need to fill out this form and return to the Bookkeeper.
- 4) **CONEXIS Form**-If the employee chooses to take the continuation of coverage this form is *fill out by the Bookkeeper*.
- 5) **Blue Cross Form, Coverage Cancellation**-This form must be *filled out by the Bookkeeper and needs to be sign by Diocesan Representative*.

If the employee decides to take Continuation of Coverage, a check made out to CONEXIS is given to the Bookkeepers along with the forms.

Once the Bookkeeper receives the information from the Employee, they should obtain proper signatures and make a copy for their files. The forms and check, if employee chooses to take coverage, is then forwarded to the Diocese. The Diocese will review the forms to make sure all paperwork is filled out properly.

SUBSECTION D

RETIREMENT

1. Retirement Information Sheet
2. DOLC Money Accumulation Plan Participant Information Sheet
3. Salary Reduction Agreement

RETIREMENT

TO PARTICIPATE YOU MUST INVEST AT LEAST 1% OF YOUR GROSS.

2 PLANS AVAILABLE:

1. MET LIFE(FORMERLY TRAVELERS)
2. FIDELITY

FIDELITY

- 403B PLAN
- FULLY VESTED IMMEDIATELY
- TAXABLE INCOME IS REDUCED
- EMPLOYEE NEEDS TO CALL FIDELITY AND ASK THEM TO SEND SOME INFO REGARDING THE DIFFERENT INVESTMENT PLANS AVAILABLE.
- FILL OUT THEIR PAPER WORK AND RETURN IT TO THEM.
- FILL OUT A SALARY REDUCTION FORM AND RETURN TO YOUR EMPLOYER.
- ONCE YOUR ACCT. IS SET UP GIVE YOUR ACCT# TO YOUR EMPLOYER.

MET LIFE (FORMERLY TRAVELERS)

- 401A PLAN
- EMPLOYEE NEEDS TO FILL OUT A TRAVELERS FORM
- TAXABLE INCOME IS NOT REDUCED
- FULLY VESTED AFTER 5 YRS
- 40% VESTED AFTER 3 YRS
- DIOCESE IS THE ADMINSTRATOR
- NO CHOICE IN INVESTMENTS
- RATE OF RETURN IS 3.40% FOR 2017
- CANNOT WITHDRAW UNTIL YOU RETIRE OR RESIGN. WHATEVER YOU PUT IN ABOVE 1% IS CONSIDERED SUPPLEMENTAL AND YOU CAN WITHDRAW THAT.

Retirement Information Sheet:

Any employee who works at least 30 hours a week is eligible for participation in one of the Diocesan retirement plans. There are three choices to choose from.

- Fidelity (403b). Call 800-343-0860 and when you call, please identify the Diocese's 403(b) account number – 67409. Deductions are made before taxes. You may choose from a range of investments. Fidelity will send a packet of information for you to complete. Please send in the forms to Fidelity and the salary reduction form to the bookkeeper. In this plan, you are immediately vested. This means that the portion that the employer contributes belongs to you when made. However, please note that you cannot withdraw funds out of this account until you resign or retire.
- Travelers (nonqualified 401a)-Complete the application (participant information form) and forward to the fiscal office. In this plan, vesting takes a full 10 years before the employee is 100% vested in this plan. There is a flat investment rate (communicated annually) and no choice of investments. You cannot withdraw your funds from this account until you retire or resign. However, this plan does allow you to contribute in excess of the minimum as a form of savings plan (supplemental). You can withdraw this amount at any time.

DIOCESE OF LAKE CHARLES - GR 05440

PARTICIPANT INFORMATION FORM

Type of Request: Enrollment Change/Suspension/Re-entry Transfer
Withdrawal Termination

Employer: _____ Location #: _____

Effective Date of Request: _____
Request Approved By: _____ Date: _____

SECTION 1 - GENERAL INFORMATION (COMPLETE FOR ALL REQUESTS)

Employee Name (Last, First, Middle Initial) _____ Social Security No _____

Street Address _____ City _____ State _____ Zip Code _____

SECTION 2 - ENROLLMENT

Date of Birth _____ Date of Hire _____ Date of Entry _____

A. Contribution Rate (Matched):

Before-Tax Contribution: _____ %
After-Tax Contribution: _____ %
Total % of Compensation: _____ %

C. Investment Election (Must total 100%):

_____ % to Fixed Investment Fund
_____ % to Equity Investment Fund

B. Contribution Rate (Unmatched):

Before-Tax Contribution: _____ %
After-Tax Contribution: _____ %
Total % of Compensation: _____ %

TOTAL (A + B) _____ %

D. Beneficiary Information:

Name and Relationship

SS#: _____

Street Address

City, State, Zip Code

I hereby elect to participate in the Plan,
and I authorize deductions and investment
elections as indicated above.

Participant's Signature

Date

SECTION 3 - CHANGE/SUSPENSION/RE-ENTRY

____ Contribution Rate Change (COMPLETE SECTION 2A & 2B) _____ Suspension

____ Investment Election Change (COMPLETE SECTION 2C) _____ Re-entry (COMPLETE SECTION 2A & 2B)

____ Name Change From: _____ (COMPLETE SECTION 1 WITH NEW NAME)

____ Beneficiary Change (COMPLETE SECTION 2D WITH CORRECT BENEFICIARY)

____ Address Change (COMPLETE SECTION 1 WITH CORRECT ADDRESS)

I hereby authorize the above changes in my Plan participation.

Participant's Signature

Date

SECTION 4 - TRANSFER

Transfer ____ % From Fixed Fund To Equity Fund
Transfer ____ % From Equity Fund To Fixed Fund

I hereby authorize the above Fund transfer of my Plan account(s).

Participant's Signature

Date

SECTION 5 - WITHDRAWAL

Type of Withdrawal: ____ Regular ____ Qualified

____ I elect to withdraw from my account(s) the amount of \$_____, or
____ I elect to withdraw from my account(s) the total amount available under this option.

Election to withhold income tax (if an election is not made, taxes will be withheld):
____ I DO WANT... ____ I DO NOT WANT... taxes to be withheld from this distribution.

I hereby authorize the above withdrawal from my Plan account(s).

Participant's Signature

Date

SECTION 6 - TERMINATION

Type of Termination: ____ Severance ____ Retirement ____ Disability ____ Death

Date of Termination (Month, Day, Year): _____ Vesting: _____ %

Benefit Election: ____ Lump Sum ____ Other: _____
____ Immediate Payment ____ Deferred Payment

Election to withhold income tax (if an election is not made, taxes will be withheld):
____ I DO WANT... ____ I DO NOT WANT... taxes to be withheld from this distribution.

Participant's Signature

Date

BENEFICIARY INFORMATION (COMPLETE FOR DEATH BENEFIT PAYMENTS ONLY):

Name: _____ Social Security No: _____ - _____ - _____

Address: _____

Date of Birth: _____
Relationship: _____

SALARY REDUCTION AGREEMENT

403 (b)(7)

Investment Firm: _____

Name of Eligible Employee: _____

Social Security Number: _____

Original Agreement

Modified Agreement

(Circle One)

I hereby acknowledge that I have been informed of my option to contribute a portion of my compensation to the Investment Firm referenced above.

_____ I elect to contribute to the Investment Firm above.

_____ I elect not to contribute to the Investment Firm above.

This agreement is made between myself and _____
(your employer). Both parties agree that as of payroll period ending _____, 2_____
your employer will reduce your annual salary by \$ _____ and each pay period
by \$ _____ or by _____ %.

(This agreement will continue in effect during the remainder of this calendar year and each succeeding calendar year.) Your employer will send your salary reduction amount to the Investment Firm listed above to purchase shares in the Fund(s) you have chosen for your retirement plan.

This agreement will automatically be renewed each year, unless you notify your employer, in writing, within 30 days prior to the date that you would like this Agreement either terminated or modified. The amount of the salary reduction can be modified only once in your taxable year. However, you can terminate this Agreement with respect to amounts not earned at the time of termination.

You are responsible for determining that the amount of your salary reduction listed above does not exceed your Maximum Exclusion Allowance, as defined in Section 403 (b)(2) of the Internal Revenue Code. Your employer will provide to you, upon request, any available information from the employer's records that is necessary to enable you to make these tax determinations.

As of _____, 2____ both Parties agree to this Salary Reduction Agreement.

Employee Signature

Employee Address

Employer Signature

Employer Address

SUBSECTION E

RESOLUTION/PROMISSORY NOTE

1. Sample Resolution
2. Sample Promissory Note

RESOLUTION

MINUTES OF THE SPECIAL MEETING OF THE BOARD OF DIRECTORS of
the _____ held at _____
_____, Louisiana on the ____ day of the month of _____,
2____.

A Special Meeting of the Board of Directors of the _____
_____ was held at _____ on the _____ day of
_____ 2____. Present were the _____
Secretary/Treasurer, _____ Trustee and
_____, Trustee. Absent was The Most Rev. Glen
J. Provost, Bishop of Lake Charles and President and Rev. Daniel A.
Torres, Vicar General and Vice President. A quorum was present.

The following resolution was introduced, duly seconded and adopted:

WHEREAS Describe the undertaking fully

_____.

BE IT RESOLVED that _____
As Secretary/Treasurer be authorized _____
In the name of _____.

BE IT RESOLVED by the Board of Directors of said Corporation that the
Secretary/Treasurer is hereby authorized to appear before a Notary Public
and to sign instruments for and on behalf of the corporation to do any and
all things necessary for the purpose of carrying out this resolution.

There being no further business to come before the Board, on motion duly
made and seconded, the meeting was adjourned.

Approved:

The Most Rev. Glen J. Provost
Bishop of Lake Charles & President

Secretary/Treasurer

Rev. Daniel A. Torres
Vicar General & Vice President

Trustee

Trustee

C E R T I F I C A T E

State of Louisiana

Parish of _____

I, the undersigned Secretary/Treasurer of the _____
_____ Louisiana, do hereby
certify that the above and foregoing is a true and correct extract of the minutes of the
meeting of the Board of Directors of the said Corporation held at _____
_____ Louisiana, on the ____ day of the month of _____ 2 _____, and that the resolutions
contained therein are still in full force and effect.

IN WITNESS WHEREOF, I have hereunto affixed my hand and the seal of this
Corporation at _____, Louisiana, this ____ day of the month of _____ 2
_____.

Secretary/Treasurer

I promise to pay to the order of _____
Catholic Church, the sum of \$ _____ at _____ per month plus
interest of _____ %, first payment due _____
in the amount of \$ _____ payable on the first day of each month
until paid in full.

Failure to pay any installment when due shall accelerate all remaining installments.

If legal activity becomes necessary to collect balance due on the note, then payee agrees
to pay an additional 25% attorney fee and any court costs.

(Borrower)

(Signature)

(Date)

SECTION F

PROPERTY LIABILITY INSURANCE

1. Consolidated Insurance program
2. General Liability Claim Information
3. Property Claim Information
4. Workers Compensation Claim Form
5. Auto Accident Form
6. Special Events Form
7. Student Accident Form
8. Volunteer Accident Form

**DIOCESE OF LAKE CHARLES
CONSOLIDATED INSURANCE PROGRAMS**

Claims Processing Effective July 1, 2018

Property, Liability

**Catholic Mutual Group
10843 Old Mill Rd., Suite 300
Omaha, Nebraska 68154-2600**

1-(800)-228-6108

Account Representative

Paula Aguilar

Property & Liability

Shawn Knoll - Claims Examiner

Mark Greenwald - Claims Supervisor

Workers' Compensation Claims

1-(985)-674-4706

**York Risk Services Group
1625 W. Causeway Approach
Mandeville, LA 70471**

Fax: 1-(614)-932-8850

Student Accident

**Bollinger, Inc.
P. O. Box 1346
Morristown, NJ 07962**

1-(866)-267-0092

Fax: 1-(973)-921-2876

Boiler & Machinery Insurance

1-(800)-228-6108

**Catholic Mutual Group
10843 Old Mill Rd., Suite 300
Omaha, Nebraska 68154-2600**

Automobile Claims

**Catholic Mutual Group
10843 Old Mill Rd., Suite 300
Omaha, NE 68154-2600**

1-(800)-228-6108

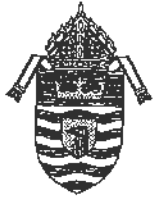
Fax: 1-(402)-551-2943

Consultant

**Tommy Jeter, Jr.
Helouin Insurance Agency
17923 W. Augusta Dr.
Baton Rouge, Louisiana 70810**

1-(225)-205-0887

Fax: 1-(225)-372-2078



Office of
Fiscal
Administration

DIOCESE OF LAKE CHARLES

414 Iris Street
P.O. Box 3223
Lake Charles, Louisiana 70602-3223
(337) 439-7400, ext. 15
FAX (337) 439-7413

TO: ALL DIOCESAN LOCATIONS

FROM: PAT MYERS *Pat*
DIRECTOR OF FISCAL AFFAIRS

RE: CLAIMS SENT TO CATHOLIC MUTUAL

DATE: JANUARY 13, 2003

Effective immediately, all future claims for Catholic Mutual are to be sent to the main office in Omaha, Nebraska. The address is as follows:

Catholic Mutual Group 1-800-228-6108
10843 Old Mill Rd., Suite 300
Omaha, Nebraska 68154-2600

Attn: Cecil Cole

The change made by Catholic Mutual to the use of a Regional Office in New Orleans was an experiment. Catholic Mutual had started this process on October 1, 2002 and some claims called into Omaha prior to my notice sent out December 17, 2002 were referred to New Orleans. Because of the service we received during this time, we in the Fiscal Department feel that it is in our best interest to go back to sending claims to Omaha and Catholic Mutual has agreed to this.

Also, attached please find some updated claim forms. Please make copies for your office and replace these forms in your Fiscal Procedure and Information Manual.

As a reminder, make sure that if you have a claim you need to fax or send a copy of the claim to the Fiscal Department.

GENERAL LIABILITY CLAIM INFORMATION

Date Of Report _____

Person Completing Report _____

LOCATION _____
ADDRESS _____

PERSON TO CONTACT _____ PHONE _____

DATE OF ACCIDENT _____

DESCRIPTION OF ACCIDENT

(Where did accident occur & description of premises?)

(What was injured doing on premises?)

NAME OF INJURED PARTY _____

OCCUPATION OF INJURED _____

PHONE NUMBERS: HOME _____ WORK _____

(Describe Injury & Where Taken)

(If property damage describe property & amount of damage)

OWNER OF PROPERTY & ADDRESS _____

WITNESSES: (Name, Address & Phone) _____

POLICE CONTACTED () YES () NO

NAME OF POLICE DEPARTMENT _____

REPORT NUMBER _____

Call Claim to:

Catholic Mutual Group
10843 Old Mill Rd., Suite 300
Omaha, NE 68154-2600

Shawn Knoll
1-800-228-6108

Mail Copy to:

Diocese of Lake Charles
Fiscal Office
P. O. Box 3223
Lake Charles, LA 70602-3223

PROPERTY CLAIM INFORMATION

Date Of Report _____ Person Completing Report _____

LOCATION _____
ADDRESS _____

PERSON TO CONTACT _____ PHONE _____
DATE OF LOSS _____

DESCRIPTION OF LOSS (Include property damage & type & extent of damage)

ADDRESS OF DAMAGED BUILDING (s) IF DIFFERENT

(If Theft) POLICE REPORT # _____ CITY _____
(If Fire) NAME OF FIRE DEPARTMENT _____
(If known report #) _____

IS BUILDING HABITABLE () YES () NO

ANY INJURIES (If So To Whom) _____

ANY DAMAGE TO PROPERTY OF OTHERS _____

COMMENTS OR ADDITIONAL INFORMATION _____

Call Claim to:

Catholic Mutual Group
10843 Old Mill Rd. Suite 300
Omaha, NE 68154-2600

Shawn Knoll
1-800-228-6108

Mail Copy to:

Diocese of Lake Charles
Fiscal Office
P. O. Box 3223
Lake Charles, LA 70602-3223

AUTOMOBILE CLAIM INFORMATION

Date of Report _____ Person Completing Report _____

LOCATION _____
ADDRESS _____

PERSON TO CONTACT _____ PHONE _____
DATE & TIME OF ACCIDENT _____ POLICE CALLED _____
LOCATION OF POLICE DEPT. (Include City and State): _____
ANY TICKETS ISSUED _____ REPORT NO. _____
LOCATION OF ACCIDENT _____ (Include City & State) _____

DESCRIPTION OF ACCIDENT _____

DESCRIPTION OF INSURED VEHICLE: Year _____ Make _____ VIN _____
INSURED DRIVER: (Name, Address, Drivers License Number & Phone) _____

DAMAGED AREA & AMOUNT OF DAMAGE _____

WHERE CAN INSURED VEHICLE BE SEEN? _____
OTHER PARTY INVOLVED: (Name, Address, Phone [home & work]) _____

DRIVER (Name, Address, Phone [home & work]) _____

TYPE OF VEHICLE & WHERE TAKEN _____

INJURED (Name, Address, Phone [home & work]) _____

WHERE TAKEN & EXTENT OF INJURY _____

WITNESSES: (Name, Address, Phone [home & work]) _____

OTHER PARTYS INSURANCE COMPANY & POLICY # _____

Call Claim to:
Catholic Mutual
10843 Old Mill Rd., Suite 300
Omaha, NE 68154-2600
Shawn Knoll
1-800-228-6108

Mail Copy to: Diocese of Lake Charles
Fiscal Office
P. O. Box 3223
Lake Charles LA 70602

Employee Social Security Number

N/A

Employer UI Account Number

72-0883986

Employer Federal ID Number

EMPLOYER: DIOCESE OF LAKE CHARLES

EMPLOYER REPORT
OF
INJURY/ILLNESS

EMPLOYEE DATE OF BIRTH: _____

This report is completed by the Employer for each injury/illness identified by them or their employee as occupational. A copy is to be provided to the employee and the insurer immediately. Forms for cases resulting in more than 7 days of disability or death are to be sent to the OWCA by the 10th day after the incident or as requested by the OWCA.

PURPOSE OF REPORT: (Check all that apply)

- ☐ More than 7 days of disability ☐ Possible dispute
☐ Injury resulted in death ☐ Lump Sum Compromise/Settlement
☐ Amputation or disfigurement ☐ Other

☐ Medical only
(no copy needed by OWCA)

| | | | | | |
|---|---|---|--|--|--|
| 1. Date of Report MM/DD/YY | 2. Date / time of injury: MM/DD/YY Time <input type="checkbox"/> AM <input type="checkbox"/> PM | 3. Normal Starting Time Day of Accident: <input type="checkbox"/> AM <input type="checkbox"/> PM | 4. If Back to Work - Give Date: MM/DD/YY | 5. At same wage? <input type="checkbox"/> Yes <input type="checkbox"/> No | DO NOT WRITE IN THIS COLUMN |
| 6. If Fatal Injury, Give Date of Death: MM/DD/YY | 7. Date Employer Knew of Injury: MM/DD/YY | 8. Date Disability began: MM/DD/YY | 9. Last Full Day Paid MM/DD/YY | | Date Received: |
| 10. Employee Name: First | Middle | Last | 11. <input type="checkbox"/> Male <input type="checkbox"/> Female | 12. Employee Phone # () | S.I.C. |
| 13. Address and Zip Code | | | | 14. Parish of Injury | State-Parish |
| 15. Date of Hire | 16. Age at Illness/Injury | 17. Occupation: | 18. Dept./Division Employed: | | Occupation |
| 19. Place of injury-Employer's Premises? <input type="checkbox"/> Yes <input type="checkbox"/> No | | 20. If No, Indicate Location-Street, City, Parish and State | | | Nature |
| 21. What work activity was the employee doing when the incident occurred? (Give weight, size and shape of materials or equipment involved. Tell what he was doing with them. Indicate if correct procedures were followed.) | | | | | Part of Body |
| | | | | | Source |
| | | | | | Event |
| | | | | | NGCI |
| 22. What caused incident to happen? (Describe fully the events which resulted in injury or disease. Tell what happened and how it happened. Name any objects or substances involved and tell how they were involved. Give full details on all factors which led to or contributed to this injury or illness.) | | | | | |
| 23. Part of Body Injured and Nature of injury or illness (ex. left leg; multiple fractures) | | | | | 24. If Occ Disease-Give Date Diagnosed: |
| 25. Physician and Address | | | | 26. If Hospitalized, give name & address of facility | |
| 27. Employer's Name | | | | 28. Person Completing This Report - Please print | |
| 29. Employer's Address and Zip Code | | | | 30. Employer's Telephone Number () | |
| 31. Employer's Mailing Address-If Different From Above | | | | 32. Nature of Business-Type of Mfg., Trade, Construction, Service, etc. | |
| 23. Wage Information (optional): Employee was paid <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other The average weekly wage was \$_____ per week | | | | | |

Name of Workers' Compensation Insurer: SELF-INSURED

Fax, Email or Mail Claim to: AVIZENT

1625 West Causeway Approach

Mandeville, LA 70471

CLAIM REPORTING FAX: (985) 624-8684 or email claim to scandocs@fara.com

Telephone: (985) 624-6716 or (800) 259-8388

EMPLOYER CERTIFICATE OF COMPLIANCE

You must submit this Certification to your workers' compensation insurer. Failure to submit this Certification as required may result in your being penalized by a fine of \$500, payable to your insurer.

You must secure workers' compensation for your employees through insurance or by becoming an authorized self-insured. If you fail to provide security for workers' compensation, you must pay an additional 50% in weekly benefits to your injured workers.

If you willfully fail to provide security for workers' compensation, then you are subject to a fine of up to \$10,000, imprisonment with or without hard labor for not more than 1 year, or both. If you have been previously fined and again fail to provide security for workers' compensation, then you are subject to additional penalties, including a court order to cease and desist from continuing further business operations.

You must not collect, demand, request, or accept any amount from any employee to pay or reimburse for the workers' compensation insurance premium. If you violate this provision, you may be punished with a fine of not more than \$500, or imprisoned with or without hard labor for not more than one year, or both.

It is unlawful for you to willfully make, or to assist or counsel someone else to make, a false statement or representation in order to obtain or to defeat workers' compensation benefits. If you violate this provision, you may be fined up to \$10,000, imprisoned with or without hard labor for up to 10 years, or both depending on the amount of benefits unlawfully obtained or defeated. In addition to these criminal penalties, you may be assessed a civil penalty of up to \$5,000.

EMPLOYER CERTIFICATION

I certify that I can read the English language, that I have read this entire document and understand its contents, and that I understand I am held responsible for this information. I certify my compliance with the Louisiana Workers' Compensation Act.

Preparer Name (PRINT)

DIOCESE OF LAKE CHARLES

Company Name

(337) 439-7400

Phone Number

Employee Name

Signature

Date

P. O. BOX 3223, LAKE CHARLES, LA 70602-3223

Company Address

SELF-INSURED

Insurance Policy Number

Employee Social Security Number

REPORT ALL CLAIMS TO:

AVIZENT

P.O. BOX 14248

JACKSON, MS 39236

CLAIM REPORTING FAX: (601) 366-3769

TELEPHONE: (601) 362-1973

Workers' Compensation

Reporting Injury

You should report to your employer any occupational disease or personal injury that is work-related, even if you deem it to be minor.

Occupational Disease or Death

In case of an occupational disease, all claims are barred unless the employee files a claim with his/her employer within one year of the date that:

- 1 the disease manifests itself.
- 2 the employee is disabled as a result of the disease.
- 3 the employee knows or has reasonable grounds to believe that the disease is occupationally related.

In case of death arising from an occupational disease, all claims are barred unless the dependent(s) file a claim with the deceased employee's employer within one year of:

- 1 the date of death.
- 2 the date the claimant has reasonable grounds to believe that the death resulted from occupational disease.

Filing Notice

In case of injury or death caused by a work-related accident, an injured employee or any person claiming to be entitled to compensation either as a claimant or as a representative of a person claiming to be entitled to compensation, must give notice to the employer within 30 days of the injury. If notice is not given within 30 days, no payments will be made for such injury or death. In addition, any fraudulent action by the employer, employee, or any other person for the purpose of obtaining or defeating any benefit or payment of workers' compensation shall subject such person to criminal as well as civil liabilities.

The above mentioned notice should be filed with the employer at the address shown to the right.

A notice so given shall not be held invalid because of any inaccuracy in stating the time, place, nature or cause of injury, or otherwise, unless it is shown that the employer was in fact misled to his detriment thereby. Failure to give notice may not harm the employee if the employer knew of the accident or if the employer was not prejudiced by the delay or failure to give notice.

Physicians

In the event you are injured, you are entitled to select a physician of your choice for treatment. The employer may choose another physician and arrange an examination which you would be required to attend.

Formal Claim

In order to preserve your right to benefits under the Louisiana Workers' Compensation Law, you must file a formal claim with the Office of Workers' Compensation Administration within one year after the accident if payments have not been made or within one year after the last payment of weekly benefits.

Information

If you desire any information regarding your rights and entitlement to benefits as prescribed by law, you may call or write to the Office of Workers' Compensation Administration, Post Office Box 94040, Baton Rouge, Louisiana 70804-9040 or telephone (225) 342-7555.

Name and Address of Insurance Company

SELF-INSURED-THIRD PARTY ADMINISTRATOR:

AVIZENT

P.O. BOX 14248

JACKSON, MS - TELEPHONE: (601) 362-1973

Notice shall be given by delivering it or sending it by certified mail or return receipt requested to:

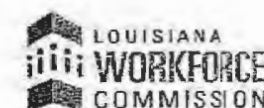
Employer Representative

Employer

DIOCESE OF
LAKE CHARLES
P.O. BOX 3223
LAKE CHARLES, LA

R.S. 23:1302 states that this notice should be posted in a convenient and conspicuous place in the employer's place of business.

Revised May 2003



www.laworks.net

**DIOCESAN AUTO
CLAIM REPORTING PROCEDURE**

In case of an accident:

Report claim immediately to:

Catholic Mutual
10843 old Mill Rd., Suite 300
Omaha, NE 68154-2600

Phone: 1-800-228-6108
Fax: 1-402-551-2943

In preparation of reporting the incident to Catholic Mutual, the following information is necessary:

| | | |
|----------------------------|-------|---------|
| Description of Accident | | |
| Date | Hour: | (AM/PM) |
| Location | | |
| Road Condition | | |
| Police Officer Name | | |
| Badge # | | |
| Police Department Location | | |
| Accident Report # | | |
| Circumstances | | |

Person(s) Injured

Name

Address

City

State

Phone

Your Vehicle

License Plate #

Make

Model

Year

Registration / Vin

Owner's Name

Driven By

Driver License #

Address

City

State

Telephone

Damage

Other Vehicle

License Plate #

Make

Model

Year

Registration/Vin

Owner's Name

Driven By

Driver License #

Address

City

Telephone

Home

Business

Damage

Insurance Company

Policy #

Witnesses

Name

Address

City

State

Telephone

DIOCESE OF LAKE CHARLES - 0338
APPLICATION FOR SPECIAL EVENTS COVERAGE

Coverage Limit: \$1,000,000 Combined Single Limit Bodily Injury and Host Liquor Liability, \$500,000 Property Damage Liability..

Includes \$100,000 for Defense Costs for Sexual Misconduct, excluding overnight events (*see below for purchase options*).

Coverage provided is per event (not per claim). **Submission of application does not bind coverage - all events are subject to approval.**

Coverage underwritten by **Nationwide Mutual Insurance Company**; Policy No. on file with C.M.G. Agency, Inc.

Cost of Coverage: \$95 Per Event (Overnight Stays - \$125)

TO AVOID DELAY OR DENIAL OF COVERAGE, PLEASE ENSURE THAT EVERY FIELD IS COMPLETED.

Name of Parish or Institution: _____

Date of Event: _____

Street (Physical) Address (NO P.O. BOXES): _____

Type of Special Event (Example: wedding reception, anniv. party, etc. If it's a **FUNDRAISER**, be specific about what is occurring):

City/State: _____ **ZIP Code:** _____

Phone No.: _____

Time of Event: From _____ To _____

Lessee (Additional Insured) Information:

Name of Sponsoring Organization or Individual Requesting Coverage: _____

Is this an overnight event? ☐ Yes ☐ No

Approx. Number of Participants: _____

(Please Print Lessee Name(s) or Organization)

Lessee (Additional Insured) Contact Person:

Name: _____

Is Food Being Served? ☐ Yes ☐ No

Street Address: _____

Is Liquor Being Served? ☐ Yes ☐ No

City/State: _____ **ZIP Code:** _____

Telephone: _____

If liquor is to be sold (or cost included in ticket price) and/or a license or permit is required in order for you to serve or furnish alcohol, you must obtain **LIQUOR LIABILITY** coverage by separate application.

Does this event require the additional coverage? ☐ Yes ☐ No

To receive approval notification please print e-mail(s):

(Please Print E-mail(s) Clearly)

patmyers@dolc.org _____

To Note: If liquor liability coverage is **NOT** purchased and an alcohol related claim results, the claim will be excluded if it is determined that a liquor liability policy should have been purchased.

**COVERAGE DOES NOT APPLY TO CERTAIN EVENTS,
 SUCH AS, BUT NOT LIMITED TO:**

- Any carnival event
- Fireworks & fireworks displays
- Events involving 'BYOB' (Bring your own bottle)
- Events involving pool or lake activities
- Events involving recreational vehicles
- Rap/Hip-Hop/Alternative music (non-religious bands)
- Events organized or operated by professional promoters/performers
- Organized sporting events, including tournaments & camps (some sporting activities are allowed and must be pre-approved).
- Events where a fee or admission is charged, unless all proceeds go to charity
- Political Rallies
- Amusement rides, including mechanically operated devices, trampolines, & rebounding devices

**DEFENSE COSTS FOR SEXUAL MISCONDUCT
 FOR OVERNIGHT EVENTS - \$100,000 LIMIT**

Coverage does not automatically apply for overnight events, however, you have the option to purchase this coverage by separate application. Additional charge may apply.

Do you want to apply for this coverage? ☐ Yes ☐ No

ADDITIONAL CHARGES WILL APPLY FOR:

- Events which exceed 3 days in duration (charge TBD)
- Inflatable Amusement Device (Must be pre-approved, picture required. Minimum charge of \$100 per inflatable applies; each device is underwritten; charge is determined by size and potential risk.)
- Events that exceed 1,000 in attendance (charge TBD)

MAKE CHECK PAYABLE TO:
DIOCESE OF LAKE CHARLES

RETURN WITH FORM TO:
 DIOCESE OF LAKE CHARLES
 CHANCERY OFFICE
 P.O. BOX 3223
 LAKE CHARLES, LA 70602

2018-19
Student Accident Claim Form
Please Read Instructions On The Next
Page Before Completing

SEND ALL FORMS TO
CLAIMS
ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 1346
Morristown, NJ 07962

| | | |
|---|--|---|
| 1. School District or Diocese: | 2. School Within District or Parish Child Attends: | 3. Master Policy No.: |
| 4. Claimant's Last Name: | First Name: | 5. Date of Birth: |
| | | 6. <input type="checkbox"/> Male <input type="checkbox"/> Female |
| 7. Telephone: | | |
| 8. Home Address: | | 9. City/State/Zip Code: |
| 10. Personal Email Address of Parent or Guardian: | | |

11. Check activity in which student was involved when injured:

A. ☐ Interscholastic Sports

B. ☐ Cheerleading ☐ Twirling or Flagwaving ☐ Band Member

Name of Sport _____

OR:

01 ☐ Physical Ed. Class

04 ☐ To and From School

07 ☐ Extra Curr. Activity ON Premises

02 ☐ Classroom or Hallway

05 ☐ Group Travel

08 ☐ Extra Curr. Activity OFF Premises

03 ☐ Playground (NOT Phys. Ed.)

06 ☐ Non-School Activity (24 Hr. Plan)

09 ☐ Spectator

Was School in Session? YES ☐ NO ☐ Starting Time _____ Dismissal Time _____

| | | |
|-------------------------------|--|-----------------------------|
| 12. Date of Accident: | 13. Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | 14. How Did Accident Occur? |
| 15. Where Did Accident Occur? | | 16. Part of Body Injured: |

17. I certify that the activity checked above is school sponsored and supervised and is covered under a policy applied for and purchased by the policyholder.

Signature of School Official _____ Title _____ Date _____

Email Address _____ Phone Number _____

AUTHORIZATIONS AND STATEMENT OF OTHER INSURANCE MUST BE
COMPLETED BY PARENT OR GUARDIAN

MEDICAL AUTHORIZATION: I authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disabilities.

PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services.

SIGNED _____ DATE _____

SIGNED _____ DATE _____

| | |
|---|--------------------------------------|
| 1. Father's Name: | 2. Name and Address of His Employer: |
| 3. Mother's Name: | 4. Name and Address of Her Employer: |
| 5. <input type="checkbox"/> No, we do not have any personal or group medical insurance. I have enclosed a letter from my employer verifying this. <input type="checkbox"/> We have no other insurance. We are (please check one): <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Yes, we do have other insurance. (Please complete #6). <input type="checkbox"/> We have a government funded plan (Medicaid, Tricare, etc.). If you have Medicaid, please supply us with a copy of your card. | |
| 6. Names of other Insurance Companies | Address |
| | |
| | |
| | |

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Parent or Guardian's Signature: _____ Date _____

PARENTS: PLEASE READ ALL INSTRUCTIONS BEFORE FILING A CLAIM:

The Accident Insurance coverage purchased by the Board of Education/School provides coverage on an **EXCESS BASIS** only. This means that only those medical expenses which are **NOT** payable by your own personal or group insurance are eligible for coverage under this policy up to the limits.

Please follow these instructions below when filing a claim:

1. **THIS CLAIM FORM MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT TO ESTABLISH YOUR CHILD'S CLAIM FILE.**

Please be sure that:

- a) The school official has completed his/her section of the claim form.
 - b) You have completed and signed the Parent's Statement and Medical Authorization.
 - c) The Statement of Other Insurance section must be fully completed.
2. Once you have sent this claim form to Bollinger, submit a claim for all medical expenses to the company that administers your personal or group insurance (including Major Medical coverage).
 3. After your primary insurance has paid the medical expenses, up to the policy limits, submit all Bills (CMS-1500 from physicians and UB-04 from hospitals) with the corresponding Explanation of Benefits from your primary insurance company as you receive them and mail to the PO Box shown below.

If this is a dental injury, your provider should submit injury related services only on an ADA Dental Form J430 or its equivalent and copies of corresponding Explanation of Benefits from your primary insurance company. Documents should be mailed to the PO Box shown below.

We cannot accept balance due bills, statements, invoices or ledgers.

4. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits.
5. Please keep a copy of this Claim Form, all bills, and primary insurance Explanation of Benefits for your own records.
6. If you need further information or have any questions, please call 866-267-0092 to speak to one of our highly qualified Customer Service Representatives between the hours of 8 a.m. and 5 p.m. E.S.T. Monday - Friday or contact us on our website www.BollingerSchools.com
PLEASE DO NOT CALL THE SCHOOL.

7. After you have submitted your completed claim form and have received your first Explanation of Benefits from Bollinger Specialty Group, you will now have a claim number and you may go to www.BollingerSchools.com to enroll and check the status of your claim online.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:

Bollinger Specialty Group

A Gallagher Company

P.O. BOX 1346, MORRISTOWN, N.J. 07962

TELEPHONE 866-267-0092

www.BollingerSchools.com

PARENTS: PLEASE READ ALL INSTRUCTIONS BEFORE FILING A CLAIM:

The Accident Insurance coverage purchased by the Board of Education/School provides coverage on an **EXCESS BASIS** only. This means that only those medical expenses which are **NOT** payable by your own personal or group insurance are eligible for coverage under this policy up to the limits.

Please follow these instructions below when filing a claim:

1. **THIS CLAIM FORM MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF ACCIDENT TO ESTABLISH YOUR CHILD'S CLAIM FILE.**

Please be sure that:

- a) The school official has completed his/her section of the claim form.
 - b) You have completed and signed the Parent's Statement and Medical Authorization.
 - c) The Statement of Other Insurance section must be fully completed.
2. Once you have sent this claim form to Bollinger, submit a claim for all medical expenses to the company that administers your personal or group insurance (including Major Medical coverage).
 3. After your primary insurance has paid the medical expenses, up to the policy limits, submit all Bills (CMS-1500 from physicians and UB-04 from hospitals) with the corresponding Explanation of Benefits from your primary insurance company as you receive them and mail to the PO Box shown below.

If this is a dental injury, your provider should submit injury related services only on an ADA Dental Form J430 or its equivalent and copies of corresponding Explanation of Benefits from your primary insurance company. Documents should be mailed to the PO Box shown below.

We cannot accept balance due bills, statements, invoices or ledgers.

4. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits.
5. Please keep a copy of this Claim Form, all bills, and primary insurance Explanation of Benefits for your own records.
6. If you need further information or have any questions, please call 866-267-0092 to speak to one of our highly qualified Customer Service Representatives between the hours of 8 a.m. and 5 p.m. E.S.T. Monday - Friday or contact us on our website www.BollingerSchools.com

PLEASE DO NOT CALL THE SCHOOL.

7. After you have submitted your completed claim form and have received your first Explanation of Benefits from Bollinger Specialty Group, you will now have a claim number and you may go to www.BollingerSchools.com to enroll and check the status of your claim online.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:



Bollinger Specialty Group

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

P.O. BOX 1346, MORRISTOWN, N.J. 07962
TELEPHONE 866-267-0092

www.BollingerSchools.com

VOLUNTEER COVERAGE

**-PLEASE READ INSTRUCTIONS
ON REVERSE SIDE
BEFORE COMPLETING-**

**SEND ALL FORMS TO
CLAIMS ADMINISTRATOR:
BOLLINGER INC.
P.O. Box 1346
Morristown, NJ 07962**

| | | | | | |
|---|--|---|--|--------------------------------------|--|
| 1. School District: | | 2. School Within District Child Attends: | | 3. Master Policy No.: MCB 0214260 | |
| 4. Claimant's Full Name: Last First Middle | | | | | |
| 5. Claimant's Full Address: | | | | | |
| 6. City: | | State: | | Zip Code: | |
| 7. E-mail address of Parent or Guardian: | | | | | |
| 8. Date of Birth: | | 9. Sex: <input type="checkbox"/> M <input type="checkbox"/> F | | 10. Telephone Number | |
| 11. Is this the first claim form completed for this accident? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| 12. Date of Accident | | 13. Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. | | 14. How Did Accident Occur? | |
| 15. Where did Accident Occur? | | | | 16. Part of Body Injured? | |

**AUTHORIZATIONS AND STATEMENT OF OTHER INSURANCE
MUST BE COMPLETED BY PARENT OR GUARDIAN**

| | | | |
|--|--|--|--|
| MEDICAL AUTHORIZATION: I authorize the release of any medical or other information necessary to process this claim, including all data covering this and/or previous confinements and/or disabilities. SIGNED _____ DATE _____ | | PAYMENT AUTHORIZATION: I authorize payment of medical benefits directly to the providers rendering services. SIGNED _____ DATE _____ | |
| 1. Father's Name: | | 2. Name and Address of His Employer: | |
| 3. Mother's Name: | | 4. Name and Address of Her Employer: | |
| 5. <input type="checkbox"/> No, we do not have any personal or group medical insurance. I have enclosed a letter from my employer verifying this. | | | |
| 6. <input type="checkbox"/> Yes, we do have other insurance. (Please complete #7). | | | |
| 7. Names of other Insurance Companies | | Address | |
| | | | |
| | | | |
| 8. <input type="checkbox"/> We have no other insurance. We are (please check one): <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled | | | |
| 9. <input checked="" type="checkbox"/> We have a government funded plan (Medicaid, TriCare, etc) | | | |

I hereby certify, swear and affirm that the information given above is true and accurate. I fully understand that any willful misrepresentation made by me in an attempt to collect benefits under this policy constitutes fraud and is punishable by law.

Parent or Guardian's Signature: _____ Date: _____

PARENTS' INSTRUCTIONS FOR FILING A CLAIM:

The Accident Insurance coverage you have purchased provides coverage on an **EXCESS BASIS** only. This means that only those medical expenses, which are **NOT** payable by your own personal or group insurance, are eligible for coverage under this policy up to the limits. Please follow these instructions below when filing a claim:

1. **THIS CLAIM FORM MUST BE MAILED TO BOLLINGER WITHIN 90 DAYS OF THE DATE OF THE ACCIDENT.**

Please be sure that:

- a) You have signed the Parent's Statement and Medical Authorization.
 - b) The Statement of Other Insurance section must be fully completed. If you are employed but have no insurance, please include a statement of verification from your employer on their letterhead.
2. IMMEDIATELY submit a claim for all medical expenses to the company that administers your personal or group insurance (including Major Medical coverage).
3. After your primary insurance has paid the medical expenses up to the policy limits, submit Itemized Bills (CMS-1500 from physicians, UB-04 from hospitals, and ADA Dental claim form J430 or its equivalent for dental injuries) **AND** copies of the Explanation of Benefits from your primary insurance company as you receive them and mail to the address shown below. **We cannot accept balance due bills.**
4. Please write the claimant's name, policy number, and date of accident on all Bills and Explanation of Benefits.
5. Please keep a copy of this Claim Form, all bills, and primary insurance Explanation of Benefits for your own records.
6. If you need further information, call 866-267-0092 or contact us on our website at www.BollingerSchools.com. **DO NOT CALL THE SCHOOL.**

Thank you for your cooperation.

NETWORK PROVIDER

www.multiplan.com

PLAN ADMINISTRATION AND CLAIM SERVICE BY:



Bollinger Specialty Group

BOLLINGER, INC., A SUBSIDIARY OF
ARTHUR J. GALLAGHER & CO.

P.O. BOX 1346, MORRISOWN N.J. 07962 • TELEPHONE 866-267-0092

www.BollingerSchools.com

**NATIONAL UNION FIRE
INSURANCE COMPANY**

MAIL CLAIM FORM TO:

MAKSIN MANAGEMENT CORP.

P.O. BOX 2648

CAMDEN, NJ 08101-2648

(800) 257-6250

www.maksin.com

NOTIFICATION OF INJURY

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Reference Number

FOR OFFICE USE

Policy Number

CHA9056312

Coverage Code

FORM MUST BE COMPLETED IN FULL & MAILED TO OUR OFFICE WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT

PART I - ACCIDENT REPORT

| | | | |
|--|--|-------------------------|---|
| 1A. Name of Organization 2011-2012 Diocese of Lake Charles Volunteer Workers & CYO | | 1B. Name of Team | |
| 2A. Name of Claimant (Last) | (First) | (Middle Initial) | 2B. Social Security No. |
| | | | 2C. Birthdate |
| 2D. Sex | | | |
| 3. Nature of Injury (Please describe fully indicating what part of body was injured - e.g. broken arm, sprained ankle, etc.) | | | |
| 4. Describe how accident occurred. (Please provide all details.) MUST BE A BODILY INJURY DUE TO AN ACCIDENT. | | | |
| 5A. Did Accident Occur: | | 5B. a) Date of Accident | 5C. Name of Activity |
| a) while the claimant was supervised? | Yes <input type="checkbox"/> No <input type="checkbox"/> | b) Time | 5D. (Check One) <input type="checkbox"/> Member/Player <input type="checkbox"/> Coach <input type="checkbox"/> Manager <input type="checkbox"/> Other |
| b) during sponsored activity? | <input type="checkbox"/> <input type="checkbox"/> | | |
| c) during programmed hours? | <input type="checkbox"/> <input type="checkbox"/> | | |
| d) on activity premises? | <input type="checkbox"/> <input type="checkbox"/> | | |
| e) while traveling directly and uninterrupted to or from a regularly scheduled activity in a supervised group? | | c) Place | 5E. Name and Title of Supervisor |
| | | | |
| 6A. Signature of Coach, Manager or Delegated Authority | | 6B. Title | 6C. Date |

PART II - TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF ADULT)

| | | | |
|---|--|---|------------------|
| 1A. Name of Father/Guardian or Claimant (if adult) <input type="checkbox"/> None | 1B. Social Security No. | 1C. Address/City/State/Zip | 1D. Phone Number |
| 2A. Name of Mother/Guardian or Spouse (if adult) <input type="checkbox"/> None | 2B. Social Security No. | 2C. Address/City/State/Zip | 2D. Phone Number |
| 3A. Name of Father/Guardian's or Claimant's (if adult) Employer <input type="checkbox"/> None | 3B. Address/City/State/Zip of Employer | | 3C. Phone Number |
| 4A. Name of Mother/Guardian's or Spouse's (if adult) Employer <input type="checkbox"/> None | 4B. Address/City/State/Zip of Employer | | 4C. Phone Number |
| 5A. List all insurance Company(ies) under which the claimant is insured <input type="checkbox"/> None | 5B. Policy Number(s) | 5C. | |
| | | <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. | |
| | | <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. | |
| | | <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. | |
| | | <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. | |
| | | <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt. | |

Affidavit: I verify that the above information regarding insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws.

Signature of Parent/Guardian or Claimant (if adult)

Date

Authorization: I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

Signature of Insured (Parent or Guardian if claimant is under 18)

Date

SEE CLAIM INSTRUCTIONS ON THE BACK OF THIS FORM

NU SR

AUTOMOBILE RECORD

PARISH _____

PARISH NUMBER _____

VIN# _____ TITLE# _____ DATE _____

| MAKE | MODEL | BODY | COLOR | YEAR | DATE ACQUIRED |
|------|-------|------|-------|------|---------------|
|------|-------|------|-------|------|---------------|

TITLE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DRIVERS

[illegible]

SECTION G

SALES TAX

1. State of Louisiana Department of Revenue –Revenue Ruling
2. Application for Exemption from Collection of Louisiana Sales Tax at Certain Fundraising Activities
3. Raffle Guidelines
4. Application for License Exemption to Conduct Charitable Gaming
5. Raffle Accountability



**Revenue Ruling
No. 13-002
February 25, 2013
Sales Tax
Taxability of Sales Made in Connection with Events Held
By Nonprofit Organizations**

La. R.S. 47:305.14 provides, among other things, an exemption from the collection of sales taxes on admissions to, parking fees associated with, and sales of tangible personal property at events held for fundraising purposes and sponsored by domestic, civic, educational, historical, charitable, fraternal, or religious organizations, which are nonprofit. A sponsoring organization will generally be considered nonprofit if it is publicly recognized and established through formal chartering or incorporation and is approved for nonprofit status under the applicable provisions of the United States Internal Revenue Code.

In addition to the above requirements, the entire proceeds of a qualifying event—with the exception of necessary expenses, such as fees for guest speakers, chair and table rentals, and food and beverage utility connected therewith—must be used for or in furtherance of the educational, charitable, religious, or historical restoration purpose of the organization. An event which is intended to yield a profit to a promoter will not meet this requirement. An individual, group or organization will generally be held to be a promoter—and thus ineligible for the exemption—where there exists an agreement between the individual, group or organization and the nonprofit to share in the net proceeds of the event or where the individual, group or organization bears a risk of loss or gain that is dependent on the success or lack of success of the event.

Unless it will be selling otherwise exempt items, a nonprofit must apply for an exemption certificate for each fundraising event. If the Department approves the application, it will issue an exemption certificate for the specific event. The certificate will evidence the Department's approval that tax need not be collected on otherwise taxable sales occurring during the eligible event.

The requirements for nonprofit organizations to make tax-free sales at fundraising events are detailed in LAC 61:I.4418. It is not the purpose of this policy statement to address all the requirements. However, examples of some common types of events—especially by school groups and youth organizations—are discussed below.

EXAMPLE 1: ORGANIZATION SELLS FOOD

Facts

Sales of food items are popular fundraising events for school and youth organizations. Such sales include cookies, popcorn, candy and other prepared food items. Other organizations run concession stands at festivals or school fairs where the sale of hamburgers, hot dogs, nachos, and other food items is common. Still, others offer the sale of prepared meals, such as jambalaya or barbeque dinners.

Analysis/Discussion

La. R.S. 47:301(10)(h) excludes from taxation sales of food items by “youth serving organizations chartered by congress.” Congressionally chartered youth serving organizations include Girl Scouts of the USA, Boy Scouts of America, and 4-H Clubs. As such, the sales of Girl Scout cookies, Boy Scout popcorn, and other food items held for sale by such organizations are exempt from the requirement to collect state sales tax without the necessity of applying for the exemption found in La. R.S. 47:305.14.

Absent qualification for the exemption found in La. R.S. 47:305.14, the sales of prepared food items by all other groups are subject to the collection of sales tax. This includes the sale of packaged food items, such as cookies, popcorn, and candy, as well as prepared food items, such as hamburgers, nachos, jambalaya and barbeque dinners.

EXAMPLE 2: ORGANIZATION TAKES ORDERS FOR THE PROMOTER

Facts

Often, schools and religious institutions raise money by taking orders and collecting money on the sale of various items, such as candles, Christmas cards, and wrapping paper. Typically, the items sold are that of a single, third-party vendor. Afterwards, the sales are compiled and an order is submitted to the third-party vendor, along with the funds collected, less the nonprofit's share of the funds collected. The third-party vendor ships the goods that were ordered to the nonprofit and the students deliver them to the purchasers.

Analysis/Discussion

La. R.S. 47:305.14(A)(2) provides that the exemption does not apply to any event “intended to yield a profit to the promoter ...” An individual, group or organization will be considered a “promoter” if the individual, group or organization shares in the net proceeds of the event with the nonprofit or if the individual, group or organization bears a risk of financial loss or gain that is dependent on the success or lack of success of the event. While this provision does not preclude the Department's approval of the tax collection exemption for an otherwise eligible event solely because the nonprofit acquires the items it is selling from a third-party vendor, the presence of a single vendor that provides order forms, sets the terms of sale, and provides promotional materials and sales incentives (such as prizes and awards for top sellers), will render the vendor a promoter. Such a finding is attributed to the risk of financial gain or loss that is borne by the third-party vendor and is dependent on the success or lack of success of the event. Accordingly, events which can be classified under this scenario will not qualify for the exemption and sales tax should be collected on any and all items held for sale by the nonprofit during the event.

EXAMPLE 3: ORGANIZATION TAKES ORDERS; NO PROMOTER IS INVOLVED

Facts

A nonprofit may have a fundraiser similar to the one described above without using a promoter. In such a scenario, the nonprofit solicits orders and then purchases goods to fill the orders from a third-party vendor, such as Sam's Club. The third-party vendor plays no role in promotion of the event.

Analysis/Discussion

Here, the third-party vendor does not appear to bear a financial risk of loss or gain that is dependent on the financial success or lack of success of the event. As such, assuming the absence of a profit-sharing agreement between the non-profit and the third-party vendor and compliance with any and all other requirements provided in La. R.S. 47:305.14 and LAC 61:I.1944, the event would be eligible to receive the exemption.

EXAMPLE 4: ORGANIZATION PURCHASES AND RESELLS MERCHANDISE

Facts

In lieu of taking orders, schools and other nonprofits often have their students or members sell various items, such as calendars or caps. The money collected is turned in to the nonprofit directly. The sale of the items is filled with pre-existing inventory which has been purchased by the nonprofit beforehand from a third-party vendor as a sale for resale. As such, the nonprofit alone bears the risk of loss associated with having unsold inventory.

Analysis/Discussion

Although the third-party vendor may recognize a profit, none of it is contingent on the success of the fundraiser. Further, the third-party vendor plays no role in promotion of the fundraiser and no profit-sharing agreement exists between the third-party vendor and the nonprofit. As such, the third-party vendor is not a "promoter" and the exemption would apply assuming compliance with any and all other requirements provided in La. R.S. 47:305.14 and LAC 61:I.1944.

EXAMPLE 5: ORGANIZATION SPONSORS MERCHANDISE FAIR

Facts

The most common type of merchandise "fair" is the school book fair. Typically, the bookseller delivers books and other merchandise to the school, along with planning materials, promotional tools, and merchandising displays. Often, the bookseller's employees come to the school to help organize the fair and arrange displays. Teachers and parent volunteers work the fair. Students and others make purchases at the bookseller's list prices. After the fair, unsold merchandise is shipped back to the bookseller. All payments are transmitted to the bookseller. An accounting is done, and the school is given an agreed upon percentage of the books sold with the bookseller keeping the remaining portion of the profits.

Analysis/Discussion

In the above scenario, there exists a profit-sharing agreement between the bookseller and the nonprofit. Such an agreement is clearly not in compliance with the requirements of La. R.S. 47:305.14(A)(2), which provides that the exemption does not apply to any event "intended to yield a profit to the promoter" Further, the bookseller bears a risk of gain or loss, as the size of its profits depend upon the success or lack of success of the event. Accordingly, the event will not qualify for the exemption and sales taxes should be collected on any and all sales during the event.

EXAMPLE 6: ORGANIZATION HOST THIRD-PARTY VENDOR

Facts

Often, schools and various nonprofits host or facilitate the sale of merchandise from third-party vendors. This scenario is most commonly seen in the sale of class rings, class photos and yearbooks. Typically, the third-party vendor of the rings or the third-party photographer comes to the school to market and sell its product to the students. Employees alone from the third-party vendor often frequent the school to distribute marketing materials and/or to take orders and hold photo sessions. After the third-party vendor collects the monies due and delivers the orders, it may give the school or other nonprofit a share of its profit derived from its sales.

Analysis/Discussion

The third-party vendor in the above scenario will be classified as a “promoter” as it bears the entire risk of gain or loss that is dependent upon the success or lack of success of the event. Further, the event is clearly intended to yield a profit to the promoter of the event—the third-party vendor. Finally, the above scenario often involves a profit-sharing agreement between the third-party vendor and the school or other nonprofit, further disqualifying the event. For all of these reasons, the event described in the above scenario will not qualify for the exemption and sales tax should be collected on the entirety of all sales made during the event.

CONCLUSION

The above examples are intended to provide guidance and constitute an illustrative list of how the provisions of La. R.S. 47:305.14 and LAC 61:1.4418 may be applied to common scenarios. Nonetheless, the qualification of each event for the exemption contained in La. R.S. 47:305.14 will be governed by the particular facts and circumstances of each case and may vary from those demonstrated above.

Tim Barfield
Executive Counsel

A Revenue Ruling is issued under the authority of LAC 61:III.101 C. A Revenue Ruling is written to provide guidance to the public and to Department of Revenue employees. It is a written statement issued to apply principles of law to a specific set of facts. A Revenue Ruling does not have the force and effect of law and is not binding on the public. It is a statement of the Department's position and is binding on the Department until superseded or modified by a subsequent change in statute, regulation, declaratory ruling, or court decision.

LOUISIANA
 DEPARTMENT of REVENUE

**Annual Application for Exemption from
 Collection of Louisiana Sales Taxes at Certain
 Fund-Raising Activities**
Louisiana Revised Statute 47:305.14

 Louisiana Department of Revenue
 P.O. Box 3278
 Baton Rouge, LA 70821-3278
 Telephone: (855) 307-3893
 Fax Number: (225) 952-2406
 Email: non.profit@la.gov
**General information
 Exclusions and Exemptions for Nonprofit Organizations**

The sales and use taxes imposed by the State of Louisiana do not apply to sales of tangible personal property at, or admission charges for, outside gate admissions to or parking fees associated with event(s) sponsored by domestic, civic, educational, historical, charitable, fraternal or religious organizations. In order to qualify for the exemption, the organization must be a domestic nonprofit organization that is exempt under IRS Code Section 501(c)(3) and the entire proceeds (except for necessary related expenses) are used for educational, charitable, religious, or historical restoration purposes or to further the organization's stated purpose.

The exemption does not apply to any event(s) intended to yield a profit to a promoter (individual or business) whose agreement with the nonprofit organization entitles the promoter to share in the gross proceeds of the event.

Any organization that endorses any candidate for political office or is otherwise involved in political activities is not eligible for the exemption.

This exemption does not exempt any organization or activity from the payment of sales or use taxes required by law to be made on purchases made by the organization. Also, this exemption does not exempt regular commercial ventures of any type such as bookstores, restaurants, gift shops, commercial flea markets, and similar activities that are sponsored by a qualifying organization that would be in competition with retail merchants.

The sponsorship of any event(s) by any organization applying for an exemption must be genuine. Sponsorship will not be considered genuine in any case in which exemption from taxation is a major consideration leading to the sponsorship.

Louisiana Revised Statute 47:305.14 allows a non-profit organization to apply for a fund-raising event exemption on an annual basis. Please include all fund-raising event(s) planned for the year. If there is more than one event, then use the supplement sheet for the additional events. Use as many supplement sheets as needed. If there is an additional fund-raising event not included the original application, then submit a supplement sheet describing the new fund-raising event along with the original fund-raising event exemption application. All applications must be submitted at least thirty days before the first fund-raising event to allow time for processing.

If approved, the nonprofit organization must inform vendors participating in the nonprofit event that state sales tax must be collected and remitted on all taxable transactions that occur during the event. If approved, the exemption certificate is only valid for the period and events listed in this application.

If the Department of Revenue denies tax exempt status under this statute, the organization may appeal the ruling to the Louisiana Board of Tax Appeals. The board may overrule the Department and grant tax exempt status if it is determined that the denial of tax exempt status was arbitrary, capricious, or unreasonable.

If you have any questions about the completion of this form, please email non.profit@la.gov.

Louisiana Department of Revenue
 P.O. Box 3278
 Baton Rouge, LA 70821-3278
 Telephone: (855) 307-3893
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LOUISIANA

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Fax Number: (225) 952-2406
Email: non.profit@la.gov

This form is for use by any nonprofit domestic, civic, educational, historical, charitable, fraternal, or religious organization when applying for exemption from the collection of state sales tax on parking fees, admissions to, or sales of tangible personal property by the organization at fund-raising events. Approval of the application does not exempt the applicant from taxes required by law to be paid on the applicant's purchases.

Answers to the questions below should be as full and complete as possible. Incomplete answers will cause the processing to be delayed or the exemption to be denied. Applications should be submitted as far in advance as possible, but no later than thirty days prior to the event. If this is a supplemental request adding or changing the fund-raising event(s), please include a copy of the original request.

Completed forms may be emailed to the Louisiana Department of Revenue at non.profit@la.gov. It may also be faxed to (225) 952-2406 or mailed to the Louisiana Department of Revenue, P.O. Box 3278, Baton Rouge, LA 70821-3278. For questions concerning the completion of this form, please call (855) 307-3893.

| | | | |
|---|--|---|--------------------------|
| Exemption Expiration Date December 31, 2017 | | | |
| Nonprofit Organization Name | | | |
| Represented by | | | Daytime Telephone Number |
| Address | | | |
| City | | | State ZIP |
| Purpose of Organization | | | |
| Does this organization endorse candidates for political office or is it otherwise involved in political activities? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| How many fund-raising events does this application cover? _____. If more than one fund-raising event, please attach supplemental sheet provided to list information. | | | |
| EVENT | | | |
| Description of Event | | | |
| Location of Event | | | |
| City | | State | ZIP Dates of Event |
| How will the proceeds, after the payment of direct necessary expenses, be used? If the proceeds are to be donated to a nonprofit organization, explain how the organization will use the funds. | | | |
| Does this event have an agreement with a promoter, individual or business that allows the promoter/individual/business to share in the proceeds from the event? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" explain: _____ | | | |
| Does any profit-seeking business enterprise, operating in the trade area where this event will be held, sell products or services that are identical or similar to the products or services that will be sold by this organization during the fund-raising event(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" explain: _____ | | | |
| If approved, the nonprofit organization must inform vendors participating in the nonprofit event that state sales tax must be collected and remitted on all taxable transactions that occur during the event. | | | |
| I hereby certify that the above-named organization is a bona fide domestic, civic, educational, historical, charitable, fraternal, or religious organization; that the organization is the actual sponsor of the event described; and that all the proceeds from the event, after necessary direct expenses, will be used to further the organization's own purpose or for the educational, charitable, religious, or historical restoration purpose stated above. The answers to the above questions are correct and complete, to the best of my knowledge and belief. I also understand that any organization that fraudulently seeks exemption under R.S. 47:305.14 shall be subject to the civil and criminal penalties provided for in the statutes. | | | |
| Representative (Please print) | | Signature | Date (mm/dd/yyyy) |
| OFFICE USE ONLY | | | |
| LDR Representative Signature | | <input type="checkbox"/> Approved: _____ (date) <input type="checkbox"/> Disapproved: _____ (date) | |
| Sales Tax Return Code: 5046 | | Sales Tax Rate: 0% (1/1/2017 - 12/31/2017) | |

LOUISIANA

DEPARTMENT of REVENUE

Annual Application for Exemption from Collection of Louisiana Sales Taxes at Certain Fund-Raising Activities

Louisiana Revised Statute 47:305.14

Louisiana Department of Revenue
P.O. Box 3278
Baton Rouge, LA 70821-3278
Telephone: (855) 307-3893
Fax Number: (225) 952-2406
Email: non_profit@la.gov

| EVENT | | | | |
|--|-------|-----|---|--|
| Description of Event | | | | |
| Location of Event | | | | |
| City | State | ZIP | Dates of Event | |
| How will the proceeds, after the payment of direct necessary expenses, be used? <i>If the proceeds are to be donated to a nonprofit organization, explain how the organization will use the funds.</i> | | | | |
| Does this event have an agreement with a promoter, individual or business that allows the promoter/individual/business to share in the proceeds from the event? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" explain: _____ | | | | |
| Does any profit-seeking business enterprise, operating in the trade area where this event will be held, sell products or services that are identical or similar to the products or services that will be sold by this organization during the fund-raising event(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" explain: _____ | | | | |
| If approved, the nonprofit organization must inform vendors participating in the nonprofit event that state sales tax must be collected and remitted on all taxable transactions that occur during the event. | | | | |
| OFFICE USE ONLY | | | | |
| LDR Representative Signature _____ | | | <input type="checkbox"/> Approved: _____ (date) <input type="checkbox"/> Disapproved: _____ (date) | |

| EVENT | | | | |
|--|-------|-----|---|--|
| Description of Event | | | | |
| Location of Event | | | | |
| City | State | ZIP | Dates of Event | |
| How will the proceeds, after the payment of direct necessary expenses, be used? <i>If the proceeds are to be donated to a nonprofit organization, explain how the organization will use the funds.</i> | | | | |
| Does this event have an agreement with a promoter, individual or business that allows the promoter/individual/business to share in the proceeds from the event? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" explain: _____ | | | | |
| Does any profit-seeking business enterprise, operating in the trade area where this event will be held, sell products or services that are identical or similar to the products or services that will be sold by this organization during the fund-raising event(s)? Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" explain: _____ | | | | |
| If approved, the nonprofit organization must inform vendors participating in the nonprofit event that state sales tax must be collected and remitted on all taxable transactions that occur during the event. | | | | |
| OFFICE USE ONLY | | | | |
| LDR Representative Signature _____ | | | <input type="checkbox"/> Approved: _____ (date) <input type="checkbox"/> Disapproved: _____ (date) | |

RAFFLE GUIDELINES

1. Raffle tickets shall be sold at only one price. Example: \$1.00 per ticket. Raffle tickets shall not be discounted, such as \$1.00 per ticket or 6 for \$5.00.
2. Raffle tickets shall be prenumbered in sequential order and shall contain at least the following information.
 - a. Organization name
 - b. Organization license number
 - c. Date, time, and location of the raffle
 - d. Prizes to be given away and their value
 - e. Cost of ticket or chance to participate
3. Pursuant to LAC 42:I.1721 (A)(3), no raffles shall be conducted where the winner must be present during a drawing to win, unless so stated on the ticket.
4. Pursuant to LAC 42:I.1721 (A)(5), the sponsoring organization shall take necessary steps to insure that each ticket purchased has a chance to be selected as the prize winner and that the prize winner is selected in a random manner.
5. Organizations shall use the form Office of Charitable Gaming Raffle Accountability Sheet for each raffle conducted. These must be maintained by the organization for a period of three years. Copies of the raffle accountability sheet can be obtained by contacting the office.
6. Pursuant to La. R.S. 4:715, only organization members or members from another licensed organization shall sell raffle tickets.
7. A raffle and a bingo game can be conducted during the same gaming session. The cost of the prize given away in conjunction with a raffle does not count towards the forty-five hundred dollar limit in accordance with La. R.S. 4:714.B.



Office of Charitable Gaming
P.O. Box 98502, Baton Rouge, LA 70804
(225) 925-1835 or (800) 562-9235 FAX (225) 925-7069

First-time Applicant ☐

Renewed ☐

Application for License Exemption to Conduct Charitable Gaming

Please type or print information:

Previous State Permit Number - E _____

| | | | |
|--|---------------------|---------------------------------------|--------------------------------------|
| Official Name of Organization (including d/b/a) | | Organization Federal Tax ID No. | Telephone No. of Organization () |
| | | E-mail address of Contact Person: | Fax No. () |
| Physical Address/Location (Street, City, State, Zip) | | | Parish |
| Official Mailing Address of Organization (Street, City, State, Zip) | | | Parish |
| Contact Person | Title/Position Held | Office Phone of Contact Person () | |
| Mailing Address of Contact Person (Street, City, State, Zip) | | Home Phone of Contact Person () | |
| Name of Building Where Game(s) are Conducted | | Owner of Building | |
| Physical Address of Building Where Game(s) are Conducted (Street, City, State, Zip) | | | Parish |
| Circle All Types of Games to be Conducted BINGO RAFFLE Other (Specify and Explain on next page) | | | |

REQUIRED INFORMATION:

1. _____ Initial here if organization has a 501-C status from IRS. Attach copy.
_____ Initial here if organization does NOT have a 501-C status. Attach by-laws/articles. If Krewe, attach parade permit.
2. If organization is school related (PTA, Booster Club, etc.), provide letter of permission from principal or other authorized school board agent.
3. What will gaming proceeds be used for? _____
4. Will rent be assessed for this gaming event? Yes ____ No ____ If yes, list amount \$ _____
5. *A minimum of 14 days notice is required before any games are allowed.
(For Raffles, include date and time of drawing(s) only.)

| Schedule of Gaming Dates and Times: | | | | |
|-------------------------------------|-----|------|------|-------|
| MONTH | DAY | YEAR | TIME | AM/PM |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Do not write below this line. For office use only.

| | | |
|-----------------------------|-----------------|---------------------------|
| Exempt? YES _____ NO _____ | IRS Code: _____ | Law / Rule Section: _____ |
| Authorizing Signature _____ | Date _____ | Exempt Permit #: E- _____ |



Office of Charitable Gaming
 P.O. Box 98602, Baton Rouge, LA 70894
 (225) 925-1835 or (800) 562-9235 FAX (225) 925-7069

Raffle Accountability Sheet

This form is to be maintained by the organization for 3 years in accordance with LAC 42:1.1731.

Organization Name _____ State License Number _____

Name of Member: _____ Phone Number: _____

Ticket Sequence Issued: _____ Date of Raffle: _____

Date Tickets Checked out to Member: _____

Date Tickets Returned to Organization: _____

Accountability:

1. Number of Tickets Issued: _____

Less:

2. Number of Tickets Unsold: _____ < _____ >

Equal:

3. Number of Tickets Sold: _____

4. Number of Ticket Stubs Returned: _____
 (By Member)
 (Lines 3 and 4 should equal)

5. Price paid per Ticket: \$ _____
 (No Discounting. EX: Buy 3 for \$1.00)

6. Total Amount Due: \$ _____
 (Multiply Line 3 by Line 5)

7. Amount Submitted By Member:
 Checks: \$ _____

Cash: \$ _____

TOTAL \$ _____

Over / Short: \$ _____

(Subtract Line 7 Total From Line 6)

If the amount is more than 0, the amount is a shortage.

If the amount is less than 0, the amount is an overage.)

I hereby certify that all information provided above is true and correct to the best of my knowledge. I hereby understand that by providing false and/or incorrect information to the Office of Charitable Gaming may subject me to penalties in accordance with LA R.S. 14:133 and LA R.S. 4:735.

Signature of Member: _____

Date: _____

Signature of Member in Charge: _____

Date: _____

SECTION IV

GROUP RULING



Office of
Fiscal
Administration

DIOCESE OF LAKE CHARLES

414 Iris Street
P.O. Box 3223
Lake Charles, Louisiana 70602
(337) 439-7400
Fax (337) 439-7413

OFFICE MEMORANDUM September 13, 2021

TO: Pastors, Principals, Vicars, Bookkeepers

FROM: Melanie Foreman
Associate Director of Finance

RE: 2021 Group Ruling (Internal Revenue Service)

Attached is your copy of the GROUP RULING issued by the Treasury Department through the General Counsel of the United States Conference of Catholic Bishops. This document deals with the tax status of organizations listed in the Official Catholic Directory.

PLEASE KEEP THIS DOCUMENT IN A PERMANENT FILE FOR FUTURE REFERENCE.

ALSO, BOOKKEEPERS: PLEASE PULL THE OLD GROUP RULING OUT OF YOUR FISCAL PROCEDURE AND INFORMATION MANUAL AND REPLACE WITH THIS ONE. PLEASE UPDATE YOUR PASTOR'S COPY AS WELL.

Internal Revenue Service
P.O. Box 2508
Cincinnati, OH 45201

Department of the Treasury

Date: September 1, 2021

Person to Contact:

R. Meyer ID# 0110429

Toll Free Telephone Number:

877-829-5500

United States Conference of Catholic
Bishops
3211 4th Street, NE
Washington, DC 20017-1194

Group Exemption Number:

0928

Dear Sir/Madam:

This responds to your July 29, 2021, request for information regarding the status of your group tax exemption.

Our records indicate that you were issued a determination letter in March 1946, that you are currently exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code, and are not a private foundation within the meaning of section 509(a) of the Code because you are described in sections 509(a)(1) and 170(b)(1)(A)(i).

With your request, you provided a copy of the *Official Catholic Directory for 2021*, which includes the names and addresses of the agencies and instrumentalities and the educational, charitable, and religious institutions operated by the Roman Catholic Church in the United States, its territories, and possessions that are subordinate organizations under your group tax exemption. Your request indicated that each subordinate organization is a non-profit organization, that no part of the net earnings thereof inures to the benefit of any individual, and that no substantial part of their activities is for promotion of legislation. You have further represented that none of your subordinate organizations is a private foundation under section 509(a), although all subordinates do not all share the same sub-classification under section 509(a). Based on your representations, the subordinate organizations in the *Official Catholic Directory for 2021* are recognized as exempt under section 501(c)(3) of the Code under GEN 0928.

Donors may deduct contributions to you and your subordinate organizations as provided in section 170 of the Code. Bequests, legacies, devises, transfers, or gifts to them or for their use are deductible for federal estate and gifts tax purposes if they meet the applicable provisions of section 2055, 2106, and 2522 of the Code.

Subordinate organizations under a group exemption do not receive individual exemption letters. Subordinate organizations are not listed in Tax Exempt Organization Search (Pub 78 data), and many are not listed in the Exempt Organizations Business Master

File extract, or EO BMF. Donors may verify that a subordinate organization is included in your group exemption by consulting the *Official Catholic Directory*, the official subordinate listing approved by you, or by contacting you directly. IRS does not verify the inclusion of subordinate organizations under your group exemption. See IRS Publication 4573, *Group Exemption*, for additional information about group exemptions.

Each subordinate organization covered in a group exemption should have its own EIN. Each subordinate organization must use its own EIN, not the EIN of the central organization, in all filings with IRS.

If you have any questions, please call us at the telephone number shown in the heading of this letter.

Sincerely,

A handwritten signature in cursive script that reads "Stephen A. Martin".

Stephen A. Martin
Director, Exempt Organizations
Rulings and Agreements



Office of the General Counsel

3211 FOURTH STREET, NE • WASHINGTON, DC 20017-1194 • 202-541-3300 • FAX 202-541-3337

DATE: September 10, 2021

TO: Subordinate Organizations under USCCB Group Ruling (GEN: 0928)

SUBJECT: 2021 Group Ruling

FROM: Anthony Picarello, General Counsel *ARP*
Madeline Obler, Assistant General Counsel

This memorandum relates to the annual Group Ruling determination letter issued to the United States Conference of Catholic Bishops (“USCCB”) by the Internal Revenue Service (“IRS”), the most recent of which is dated September 1, 2021, with respect to the federal tax status of subordinate organizations listed in the 2021 edition of the Official Catholic Directory (“OCD”).¹ As explained in greater detail below, this 2021 Group Ruling determination letter is important for establishing:

- (1) exemption of subordinate organizations under the USCCB Group Ruling from federal income tax; and
- (2) deductibility of contributions to such organizations for federal income, gift, and estate tax purposes.

The 2021 Group Ruling determination letter is the latest in a series that began with the original determination letter of March 25, 1946. In the original 1946 letter, the Treasury Department affirmed the exemption from federal income tax of all Catholic institutions listed in the OCD for that year. Each year since 1946, in a separate letter, the 1946 ruling has been reaffirmed with respect to subordinate organizations listed in the current edition of the OCD.² The annual group ruling letter clarifies important tax consequences for Catholic institutions listed in the OCD, and should be retained for ready reference. Group Ruling letters from prior years establish tax consequences with respect to transactions occurring during those years.

UBIT on Fringe Benefits. Taxpayer Certainty and Disaster Relief Act of 2019, Public Law 116-94, enacted in December 2019, repealed section 512(a)(7) to the Internal Revenue Code (“Code”), which subjected tax-exempt organizations to unrelated business income tax (“UBIT”) to the extent they pay or incur expenses for any qualified transportation fringe described in

¹ A copy of the most recent Group Ruling determination letter and this memo may be found on the General Counsel's "Tax and Group Ruling" page.

² Catholic organizations with independent IRS exemption determination letters are listed in the 2021 OCD with an asterisk (*), which indicates that such organizations are **not** included in the Group Ruling.

section 132(f) and any parking facility used in connection with qualified parking (the “parking lot tax”). As the repeal was retroactive to the date of enactment, exempt organizations can request refunds of amounts paid in tax years 2018 and 2019 toward the parking lot tax. Exempt organizations seeking refunds for amounts paid in 2018 may file an amended Form 990-T, and exempt organizations seeking a refund for estimated taxes paid toward the parking lot tax in 2019 are advised to file Form 4466, *Corporation Application for Quick Refund of Overpayment of Estimated Tax*, to receive a refund of amounts paid toward 2019.

Responsibilities under Group Ruling. Diocesan officials who compile OCD information for submission to the OCD publisher are responsible for the accuracy of such information. They must ensure that only qualified organizations are listed, that organizations are listed under their correct legal names, that organizations that cease to qualify are deleted promptly, and that newly-qualified organizations are listed as soon as possible.

EXPLANATION

1. **Exemption from Federal Income Tax.** The latest Group Ruling determination letter reaffirms that the agencies and instrumentalities and educational, charitable, and religious institutions operated, supervised or controlled by or in connection with the Roman Catholic Church in the United States, its territories or possessions that appear in the 2021 OCD and are subordinate organizations under the Group Ruling are recognized as exempt from federal income tax and described in section 501(c)(3) of the Code. The Group Ruling determination letter does not cover organizations listed with asterisks or any foreign organizations listed in the 2021 OCD.

Verification of Exemption under Group Ruling. The latest Group Ruling determination letter indicates that subordinate organizations are not listed in Tax Exempt Organization Search (Pub. 78 data) (“TEOS,” formerly “EO Select Check”), and many are not listed in the Exempt Organizations Business Master File extract, or EO BMF. As a result, many subordinate organizations included in the USCCB Group Ruling are not included in various online databases (e.g., GuideStar) that are derived from the EO BMF. This does not mean that subordinate organizations included in the Group Ruling are not tax exempt, that contributions to them are not deductible, or that they are not eligible for grant funding from corporations, private foundations, sponsors of donor-advised funds or other donors that rely on online databases for verification of tax-exempt status. It does mean that a Group Ruling subordinate may have to make an extra effort to document its eligibility to receive charitable contributions. The Group Ruling determination letter states that donors may verify that a subordinate organization is included in the Group Ruling by consulting the Official Catholic Directory or by contacting the USCCB directly. It also states that the IRS does not verify inclusion of subordinate organizations under the Group Ruling. *Accordingly, neither subordinate organizations nor donors should contact the IRS to verify inclusion under the Group Ruling.*

Subordinate organizations should refer donors, including corporations, private foundations, and sponsors of donor-advised funds, to the specific language in the Group Ruling determination letter regarding verification of tax-exempt status and to IRS Publication 4573,

Group Exemptions, available on the IRS website at www.irs.gov.³ Publication 4573 explains that: (1) the IRS does not determine which organizations are included in a group exemption; (2) subordinate organizations exempt under a group exemption do not receive their own IRS determination letters; (3) exemption under a group ruling is verified by reference to the official subordinate listing (e.g., the Official Catholic Directory); and (4) it is not necessary for an organization included in a group exemption to be listed in TEOS or the EO BMF. Although not required, organizations in the Group Ruling may be included in the EO BMF, and consequently, online databases derived from it.

2. **Public Charity Status.** The latest Group Ruling determination letter recognizes that subordinate organizations included in the 2021 OCD are public charities and not private foundations under section 509(a) of the Code, but that all subordinate organizations do not share the same public charity status under section 509(a). Therefore, although the USCCB is classified as a public charity under sections 509(a)(1) and 170(b)(1)(A)(i), that public charity status does *not* automatically extend to subordinate organizations covered under the Group Ruling.

Verification of Public Charity Status. Each subordinate organization in the Group Ruling must establish its own public charity status under section 509(a)(1), 509(a)(2), or 509(a)(3) as a condition to inclusion in the Group Ruling. Certain types of subordinate organizations included in the Group Ruling qualify as public charities by definition under the Code. These are:

- churches and conventions or associations of churches under sections 509(a)(1) and 170(b)(1)(A)(i) (generally limited to dioceses, parishes and religious orders);
- elementary and secondary schools, colleges and universities under sections 509(a)(1) and 170(b)(1)(A)(ii); and
- hospitals under sections 509(a)(1) and 170(b)(1)(A)(iii).

Other subordinate organizations covered under the Group Ruling may qualify under the public support tests of either sections 509(a)(1) and 170(b)(1)(A)(vi) or section 509(a)(2). Verification of public charity classification under either of the support tests generally can be established by providing a written declaration of the applicable classification signed by an officer of the organization, along with a reasoned written opinion of counsel and a copy of Schedule A of Form 990/EZ, if applicable. Large institutional donors, such as private foundations and sponsors of donor-advised funds, may require this verification prior to making a contribution or grant to be assured that the grantee is not a Type III non-functionally integrated supporting organization.⁴ A subordinate organization included in the Group Ruling may want to file Form 8940, Request for Miscellaneous Determination, with the IRS to request a determination that it is a publicly supported charity described in sections 509(a)(1) and 170(b)(1)(A)(vi) or section

³ For an illustration of how exemption verification works, refer to the “Information for Donors and Grantmakers” link on the USCCB website “Tax and Group Ruling.” page.

⁴ See Notice 2014-4, 2014-2 I.R.B (January 6, 2014).

509(a)(2), or is a Type I or II supporting organization, in order to satisfy private foundations and sponsors of donor-advised funds regarding its public charity status.

3. **Deductibility of Contributions.** The latest Group Ruling determination letter assures donors that contributions to subordinate organizations listed in the 2021 OCD are deductible for federal income, gift, and estate tax purposes.

4. **Unemployment Tax.** As section 501(c)(3) organizations, subordinate organizations covered by the Group Ruling are exempt from *federal* unemployment tax. However, individual states may impose unemployment tax on subordinate organizations even though they are exempt from federal unemployment tax. Please consult a local tax advisor about any state unemployment tax questions.

5. **Social Security Tax.** All section 501(c)(3) organizations, including churches, are required to withhold and pay taxes under the Federal Insurance Contributions Act (FICA) for each employee.⁵ However, services performed by diocesan priests in the exercise of their ministry are not considered “employment” for FICA (Social Security) purposes.⁶ FICA should not be withheld from their salaries. *For Social Security purposes*, diocesan priests are subject to self-employment tax (“SECA”) on their salaries as well as on the value of meals and housing or housing allowances provided to them.⁷ Neither FICA nor income tax withholding is required on remuneration paid directly to religious institutes for members who are subject to vows of poverty and obedience and are employed by organizations included in the Official Catholic Directory.⁸

6. **Federal Excise Tax.** Inclusion in the Group Ruling has no effect on a subordinate organization's liability for federal excise taxes. Exemption from these taxes is very limited. Please consult a local tax advisor about any excise tax questions.

7. **State/Local Taxes.** Inclusion in the Group Ruling does not automatically establish a subordinate organization's exemption from state or local income, sales, or property taxes. Typically, separate exemptions must be obtained from the appropriate state or local tax authorities in order to qualify for any applicable exemptions. Please consult a local tax advisor about any state or local tax exemption questions.

8. **Form 990/EZ/N.** All subordinate organizations included in the Group Ruling must file Form 990, Return of Organization Exempt from Income Tax, Form 990-EZ, Short Form Return of Organization Exempt From Income Tax, or Form 990-N, e-Postcard, *unless* they

⁵ Section 3121(w) of the Code permits certain church-related organizations to make an irrevocable election to avoid payment of FICA taxes, but only if such organizations are opposed for religious reasons to payment of social security taxes.

⁶ I.R.C. § 3121(b)(8)(A).

⁷ I.R.C. § 1402(a)(8).

⁸ Rev. Rul. 77-290, 1977-2 C.B. 26. *See also* OGC/LRCR Memorandum on Compensation of Religious, (September 11, 2006).

are eligible for a mandatory or discretionary exception to this filing requirement. ***There is no automatic exemption from the Form 990/EZ/N filing requirement simply because an organization is included in the Group Ruling or listed in the OCD.*** Subordinate organizations must use their own EIN to file Form 990/EZ/N. **Do not** use the EIN of the USCCB or an affiliated parish, diocese or other organization to file a return. Form 990/EZ/N is due by the 15th day of the fifth month after the close of an organization's fiscal year.⁹ The following organizations are not required to file Form 990/EZ/N: (i) churches and conventions or associations of churches; (ii) integrated auxiliaries;¹⁰ (iii) the exclusively religious activities of religious orders; and (iv) schools below college level affiliated with a church or operated by a religious order.¹¹ Organizations should exercise caution if they choose not to file a Form 990/EZ/N because they believe they are not required to do so. If IRS records indicate that the organization should file a Form 990/EZ/N each year (for example, the organization receives an IRS notice stating that it failed to file a return for a given year), then the organization may appear on the auto-revocation list notwithstanding its claim to being exempt from the filing requirement.

Which form an organization is required to file usually depends on the organization's gross receipts or the fair market value of its assets.

| Gross receipts or fair market value of assets | Return required |
|---|---|
| Gross receipts normally not more than \$50,000 (regardless of total assets) | 990-N (but may file a Form 990 or 990-EZ) |
| Gross receipts < \$200,000, <i>and</i> Total assets < \$500,000 | 990-EZ (but may file a Form 990) |
| Gross receipts ≥ \$200,000, <i>or</i> Total assets ≥ \$500,000 | 990 |

Special Rules for Section 509(a)(3) Supporting Organizations. Every supporting organization described in section 509(a)(3) included in the Group Ruling must file a Form 990 or Form 990-EZ (and not Form 990-N) each year, unless (i) the organization can establish that it is an integrated auxiliary of a church within the meaning of Treas. Reg. § 1.6033-2(h) (in which case the organization need not file Form 990/EZ *or* Form 990-N); or (ii) the organization's gross receipts are normally not more than \$5,000, in which case, the religious supporting organization

⁹ The penalty for failure to file the Form 990/EZ is \$20 for each day the failure continues, up to a maximum of \$10,000 or 5 percent of the organization's gross receipts, whichever is less. However, organizations with annual gross receipts in excess of \$1 million are subject to penalties of \$100 per day, up to a maximum of \$50,000. I.R.C. § 6652(c)(1)(A). There is no monetary penalty for failing to file or filing late a Form 990-N.

¹⁰ I.R.C. § 6033(a)(3)(A)(i); Treas. Reg. § 1.6033-2(h).

¹¹ Treas. Reg. § 1.6033-2(g)(1)(vii).

may file Form 990-N in lieu of a Form 990 or Form 990-EZ.

Automatic Revocation for Failure to File a Required Form 990/EZ/N. Any organization that does not file a required Form 990/EZ/N for three consecutive years automatically loses its tax-exempt status under section 6033(j). If an organization loses its tax-exempt status under section 6033(j), it must file an application (Form 1023 or Form 1023-EZ) with the IRS to reinstate its tax-exempt status. See the IRS website (charities and non-profits) at www.irs.gov/charities-non-profits / for information on automatic revocation, including the current list of revoked organizations and guidance about reinstatement of exemption.

Public Disclosure and Inspection. Subordinate organizations required to file Form 990/EZ¹² must upon request make a copy of the form and its schedules (other than contributor lists) and attachments available for public inspection during regular business hours at the organization's principal office and at any regional or district offices having three or more employees. Form 990/EZ for a particular year must be made available for a three year period beginning with the due date of the return.¹³ In addition, any organization that files Form 990/EZ must comply with written or in-person requests for copies of the form. The organization may impose no fees other than a reasonable fee to cover copying and mailing costs. If requested, copies of the forms for the past three years must be provided. In-person requests must be satisfied on the same day. Written requests must be satisfied within 30 days.¹⁴

Public Disclosure of Form 990-T. Form 990-T, Exempt Organization Unrelated Business Income Tax Return, for organizations exempt under section 501(c)(3) (which includes all organizations in the USCCB Group Ruling) is subject to rules similar to those for public inspection and copying of Forms 990/EZ.¹⁵

Group Returns. USCCB does not file a group return Form 990 on behalf of any organizations in the Group Ruling. In addition, no subordinate organization under the Group Ruling is authorized to file a group return for its own affiliated group of organizations.

¹² Form 990-N is available for public inspection at no cost through the IRS website at www.irs.gov.

¹³ The penalty for failure to permit public inspection of the Form 990 is \$20 for each day during which such failure continues, up to a maximum of \$10,000. I.R.C. § 6652(c)(1)(C).

¹⁴ I.R.C. § 6104(d). Generally, a copy of an organization's exemption application and supporting documents must also be provided on the same basis. However, since organizations included in the Group Ruling do not file exemption applications with the IRS, nor did the USCCB, organizations included in the Group Ruling should respond to requests for public inspection and written or in-person requests for copies by providing a copy of the page of the current OCD on which they are listed. If a covered organization does not have a copy of the current OCD, it has two weeks within which to make it available for inspection and to comply with in-person requests for copies. Written requests must be satisfied within the general time limits.

¹⁵ Only the Form 990-T itself, and any schedules, attachments, and supporting documents that relate to the imposition of tax on the unrelated business income of the organization, are required to be made available for public inspection.

For more information, refer to *Annual Filing Requirements for Catholic Organizations*, available at www.usccb.org/about/general-counsel/ under “Tax and Group Ruling.”

9. **Certification of Racial Nondiscrimination by Private Schools in Group Ruling.** Revenue Procedure 75-50¹⁶ sets forth notice, publication,¹⁷ and recordkeeping requirements regarding racially nondiscriminatory policies with which private schools, including church-related schools, must comply as a condition of establishing and maintaining exempt status under section 501(c)(3) of the Code. Under Rev. Proc. 75-50 private schools are required to file an annual certification of racial nondiscrimination with the IRS. For private schools not required to file Form 990, the annual certification must be filed on Form 5578, Annual Certification of Racial Nondiscrimination for a Private School Exempt from Federal Income Tax. This form is available at www.irs.gov. Form 5578 must be filed by the 15th day of the fifth month following the close of the fiscal year. Form 5578 may be filed by an individual school or by the diocese on behalf of all schools operated under diocesan auspices. The requirements of Rev. Proc. 75-50 remain in effect and must be complied with by all schools listed in the OCD. ***Diocesan or school officials should ensure that the requirements of Rev. Proc. 75-50 are met since failure to do so could jeopardize the tax-exempt status of the school and, in the case of a school not legally separate from the church, the tax-exempt status of the church itself.*** For more information, refer to *Annual Filing Requirements for Catholic Organizations*, available at www.usccb.org/about/general-counsel/ under “Tax and Group Ruling.”

10. **Lobbying Activities.** Subordinate organizations under the Group Ruling may lobby for changes in the law, provided such lobbying is not more than an insubstantial part of their total activities. Attempts to influence legislation both directly and through grassroots lobbying at the federal, state, or local levels are subject to this restriction. The term “lobbying” includes activities in support of or in opposition to referenda, constitutional amendments, and similar ballot initiatives. There is no distinction between lobbying activity that is related to a subordinate organization’s exempt purposes and lobbying that is not. There is no fixed percentage that constitutes a safe harbor for “insubstantial” lobbying. Please consult a local tax advisor about any lobbying activity questions. For more information, refer to *Political Activity and Lobby Guidelines for Catholic Organizations*, available at www.usccb.org/about/general-counsel/ under “Tax and Group Ruling.”

11. **Political Activities.** ***Subordinate organizations under the Group Ruling may not participate or intervene in any political campaign on behalf of or in opposition to any***

¹⁶ 1975-2 C.B. 587.

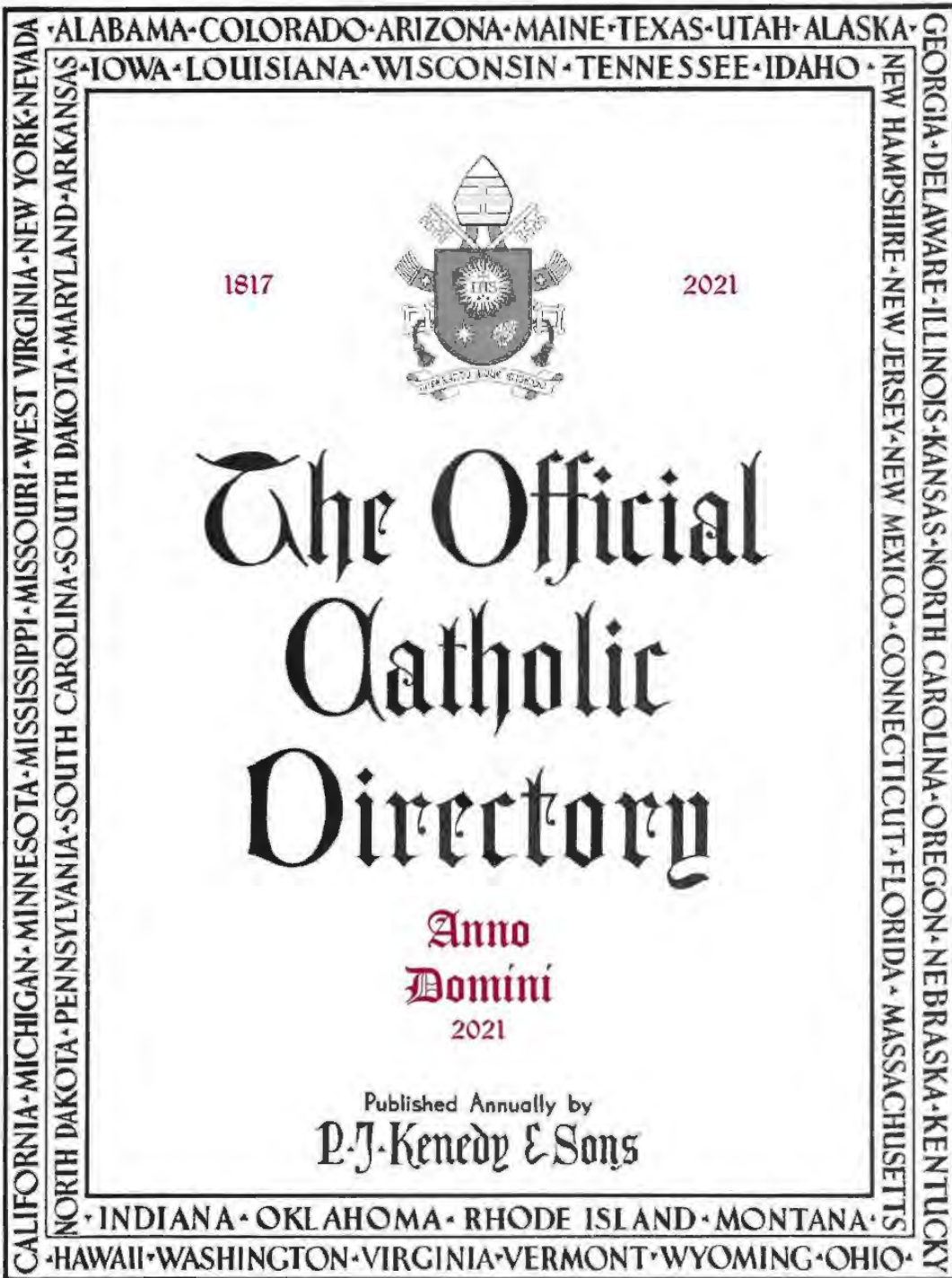
¹⁷ Revenue Procedure 2019-22, 2019-22 I.R.B. 1260, revised Revenue Procedure 75-50 to include a third method by which a private school may make its racially nondiscriminatory policy known to all segments of the general community the school serves. The school may now display a notice of its racially nondiscriminatory policy on its primary publicly accessible Internet homepage at all times during the tax year (excluding temporary outages due to website maintenance or technical problems) in a manner reasonably expected to be noticed by visitors to the homepage.

candidate for public office. Violation of the prohibition against political campaign intervention can jeopardize the organization's tax-exempt status. In addition to revoking tax-exempt status, IRS may also impose excise taxes on an exempt organization and its managers on account of political expenditures. Please consult a local tax advisor about any political campaign intervention questions. For more information, refer to *Political Activity and Lobby Guidelines for Catholic Organizations*, available at www.usccb.org/about/general-counsel/ under “Tax and Group Ruling.”

12. **Group Exemption Number (“GEN”)**. The group exemption number or GEN assigned to the USCCB Group Ruling is 0928. *This number must be included on each Form 990/EZ, Form 990-T, and Form 5578 required to be filed by a subordinate organization under the Group Ruling.*¹⁸ We advise *against* using GEN 0928 on Form SS-4, Request for Employer Identification Number, because in the past this has resulted in the IRS improperly including the USCCB as part of the subordinate organization's name in IRS records.

13. **Employer Identification Numbers (“EINs”)**. Each subordinate organization under the Group Ruling must have and use its own EIN. **Do not** use the EIN of the USCCB or an affiliated parish, diocese, or other organization in any filings with IRS (*e.g.*, Forms 941, W-2, 1099, or 990/EZ) or other financial documents. Subordinate organizations may *not* use USCCB’s EIN in order to qualify for online donations, grants or matching gifts.

¹⁸ The IRS has expressed concern about organizations covered under the Group Ruling that fail to include the group exemption number (0928) on their Form 990/EZ/T filings, particularly the initial filing.



1817

2021

The Official Catholic Directory

Anno
Domini
2021

Published Annually by
P.J. Kennedy & Sons

Diocese of Lake Charles



Most Reverend GLEN JOHN PROVOST

Bishop of Lake Charles; ordained June 29, 1975; appointed Bishop of Lake Charles March 6, 2007; ordained April 23, 2007. *Chancery Office:* 414 Iris St., P.O. Box 3223, Lake Charles, LA 70602. T: 337-439-7400; F: 337-439-7413.

Chancery Office: 414 Iris St., P.O. Box 3223, Lake Charles, LA 70602. T: 337-439-7400; F: 337-439-7413.

lediocese.org
info@lediocese.org

ESTABLISHED APRIL 25, 1980.

Square Miles 5,313.

Comprises the civil parishes (or counties) of Allen, Beauregard, Calcasieu, Cameron and Jefferson Davis in the State of Louisiana.

For legal titles of parishes and diocesan institutions, consult the Chancery Office.

STATISTICAL OVERVIEW

| | | | | | |
|-------------------------------------|----|---|---------|---|---------|
| Personnel | | | | | |
| Bishop | 1 | Sisters | 8 | Elementary Students | 2,276 |
| Priests: Diocesan Active in Diocese | 30 | Lay Ministers | 880 | Total Students under Catholic Instruction | 18,426 |
| Priests: Retired, Sick or Absent | 15 | Welfare | | Teachers in the Diocese: | |
| Number of Diocesan Priests | 45 | Catholic Hospitals | 2 | Priests | 1 |
| Religious Priests in Diocese | 17 | Total Assisted | 136,272 | Sisters | 4 |
| Total Priests in Diocese | 62 | Homes for the Aged | 1 | Lay Teachers | 227 |
| Extern Priests in Diocese | 3 | Total Assisted | 85 | Vital Statistics | |
| Ordinations: | | Day Care Centers | 1 | Receptions into the Church: | |
| Diocesan Priests | 4 | Total Assisted | 30 | Infant Baptism Totals | 728 |
| Transitional Deacons | 1 | Special Centers for Social Services | 3 | Adult Baptism Totals | 58 |
| Permanent Deacons in Diocese | 22 | Total Assisted | 144,012 | Received into Full Communion | 157 |
| Total Brothers | 1 | Educational | | First Communions | 810 |
| Total Sisters | 17 | Diocesan Students in Other Seminaries | 5 | Confirmations | 245 |
| Parishes | | Total Seminarians | 5 | Marriages: | |
| Parishes | 39 | Colleges and Universities | 1 | Catholic | 198 |
| With Resident Pastor: | | Total Students | 13,000 | Interfaith | 56 |
| Resident Diocesan Priests | 22 | High Schools, Diocesan and Parish | 1 | Total Marriages | 254 |
| Resident Religious Priests | 16 | Total Students | 540 | Deaths | 693 |
| Without Resident Pastor: | | Elementary Schools, Diocesan and Parish | 6 | Total Catholic Population | 61,981 |
| Administered by Priests | 1 | Total Students | 1,717 | Total Population | 306,139 |
| Missions | 6 | Catechesis/Religious Education: | | | |
| Professional Ministry Personnel: | | High School Students | 888 | | |

Former Bishops—Most Revs. JUDE SPEYER, D.D., ord. July 25, 1953; appt. First Bishop of Lake Charles Jan. 29, 1980; ord. and installed April 25, 1980; resigned Dec. 12, 2000; died July 21, 2013.; EDWARD K. BRAXTON, ord. May 13, 1970; appt. Auxiliary Bishop of St. Louis March 28, 1995; ord. Auxiliary Bishop of St. Louis May 17, 1995; appt. Bishop of Lake Charles Dec. 12, 2000; installed Feb. 22, 2001; appt. Bishop of Belleville March 15, 2005.

Bishop's Office—414 Iris St., P.O. Box 3223, Lake Charles, 70602. T: 337-439-7400, Ext. 204.

Chancery Office—414 Iris St., P.O. Box 3223, Lake Charles, 70602. T: 337-439-7400; F: 337-439-7413. Office Hours: Mon.-Fri. 8:30-4:30.

Bishop Perry Building—411 Iris St., Lake Charles, 70601. T: 337-439-7426; F: 337-439-7428. Office Hours: Mon.-Fri. 8:30-4:30.

Vicar General (Pastoral Services)—Rev. Msgr. DANIEL A. TORRES, V.G., Mailing Address: P.O. Box 3223, Lake Charles, 70602. T: 337-439-7400.

Moderator of the Curia and Vicar General (Administration)—Very Rev. RUBEN J. BULLER, V.G.

Chancellor—Deacon GEORGE STEARNS, P.O. Box 3223, Lake Charles, 70602. T: 337-439-7400, Ext. 220.

Vice Chancellor—Very Rev. RUBEN VILLARREAL, Ph.L., J.C.L.

Tribunal—414 Iris St., P.O. Box 3223, Lake Charles, 70602. T: 337-439-7400, Ext. 210. Very Rev. RUBEN VILLARREAL, Ph.L., J.C.L., Judicial Vicar.

Judges—Rev. Msgr. JACE F. ESKIND, J.C.L.; Ms. BONNIE LANDRY, J.C.L.; Rev. JOHN PAYNE, J.C.L.

Advocates—Sr. MARIA REGINA OSONDU, D.M.M.M.; JESSICA WILSON.

Defenders of the Bond—Rev. ALBERT W. BOREL, J.C.L.; Rev. Msgr. HARRY D. GREIG II; Rev. DEAN BRIAN THOMPSON, J.C.L.

Notary—MRS. DEBRA FOREMAN.

Promoter of Justice—Rev. DEAN BRIAN THOMPSON, J.C.L.

Deans—Very Revs. EDWARD J. RICHARD, M.S., West Deanery; ROJO ANTONY PALATTY KOONATHAN, H.G.N., South Central Deanery; MATTHEW CORMIER, North Central Deanery; KEITH PELLERIN, East Deanery.

Presbyteral Council—Very Revs. AUBREY V. GUILBEAU, Chm.; RUBEN J. BULLER, V.G., Sec.; ROJO ANTONY PALATTY KOONATHAN, H.G.N.; Rev. JOSE VATTAKUNNEL, M.C.; Rev. Msgr. JAMES GADDOY, (Retired); Rev. BRIAN MADISON KING, Very Rev. EDWARD J. RICHARD, M.S.; Rev. Msgr. DANIEL A. TORRES, V.G.; Very Rev. MATTHEW CORMIER; Revs. PAUL JUSSEN, M.S.; MICHAEL EUGENE CARAWAY; ALAN P. TROUILLE; JEFFREY PAUL STARKOVICH; Very Revs. KEITH PELLERIN; RUBEN VILLARREAL, Ph.L., J.C.L.

Diocesan Consultors—Very Rev. MATTHEW CORMIER; Rev. Msgr. DANIEL A. TORRES, V.G.; Very Revs. AUBREY V. GUILBEAU; RUBEN J. BULLER, V.G.; Rev. Msgr. JAMES GADDOY, (Retired), (convener of the college); Revs. ANTHONY M. FONTENOT; JOSE VATTAKUNNEL, M.C.; SUSIL FERNANDO; Very Revs. ROJO ANTONY PALATTY KOONATHAN, H.G.N.; EDWARD J. RICHARD, M.S.

Offices, Boards, Commissions, Committees

Black Catholics—Deacon EDWARD LAVINE, P.O. Box 3223, Lake Charles, 70601.

T: 337-439-7436, Ext. 11.

Clergy Formation—Rev. NATHAN LUNG, 411 Iris St., Lake Charles, 70601. T: 337-439-7400.

Communications—Mailing Address: P.O. Box 3223, Lake Charles, 70601. MORRIS LEBLUE, Dir., T: 337-439-7400, Ext. 304; PAMELA SEALS, Assoc. Dir.

Counseling—Rev. WHITNEY MILLER, St. Charles Retreat Center, 2151 Sam Houston Jones Pkwy., Moss Bluff, 70611.

Deaf Apostolate—Very Rev. AUBREY V. GUILBEAU, 418 Iris St., Lake Charles, 70601. T: 337-439-4373.

Development Office—STEPHANIE RODRIGUE, Dir. Devel., T: 337-439-7400 Ext. 307; MORRIS LEBLUE, Assoc. Dir., Mailing Address: P.O. Box 3223, Lake Charles, 70602. T: 337-439-7400, Ext. 304.

Diocesan Building Commission—Deacon GEORGE STEARNS, Chm., P.O. Box 3223, Lake Charles, 70602. T: 337-439-7400, Ext. 204.

Vocation Director & Director of Seminarians—Rev. JEFFREY PAUL STARKOVICH, 414 Iris St., Lake Charles, 70601. T: 337-439-7400.

Education—MRS. KIMBERLEE GAZZOLLO, Supt., Mailing Address: P.O. Box 3223, Lake Charles, 70602. T: 337-439-7426, Ext. 18.

Evangelization—411 Iris St., Lake Charles, 70601. Sr. MARIE ROSE RUDEK, R.S.M.

Fiscal Administration—Mailing Address: P.O. Box 3223, Lake Charles, 70602. Deacon BRIAN KIRK, CFO, T: 337-439-7400, Ext. 203.

Hispanic Ministry—Deacon JOSUE CANELO, Dir., Saint Henry Catholic Church, 1021 8th Ave., Lake Charles, 70601. T: 337-436-7223.

Office of Liturgy—Diocese of Lake Charles: 414 Iris St., Lake Charles, 70601. T: 337-439-7400, Ext. 217. Rev. SAMUEL E. BOND, Dir.

Parish Boundaries Commission—Rev. Msgr. DANIEL A. TORRES, V.G., Chm., Mailing Address: P.O. Box 3223, Lake Charles, 70602.

T: 337-439-7400, Ext. 204.

Permanent Diaconate—Deacon JAMES DALE DESHOTEL, Chm.

Personnel Board—Rev. Msgr. DANIEL A. TORRES, V.G.; Very Revs. AUBREY V. GUILBEAU; KEITH PELLERIN; ROJO ANTONY PALATTY KOONATHAN, H.G.N.; MATTHEW CORMIER; EDWARD J. RICHARD, M.S.; RUBEN J. BULLER, V.G.

Propagation of the Faith: Rev. ANTHONY M. FONTENOT.

LAKE CHARLES (LKC)

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CATHOLIC CHURCH IN THE U.S.

Mailing Address: 7880 Gulf Hwy., Lake Charles, 70607. T: 337-478-0213; F: 337-478-0793.
Religious Education—411 Iris St., Lake Charles, 70601. Sr. MARIE ROYCE, R.S.M.
Relief Services Catholic—Rev. ANTHONY M. FONTENOT.
 Mailing Address: 7880 Gulf Hwy., Lake Charles, 70607.
St. Charles Retreat Center—2151 Sam Houston Jones

Phwy., Lake Charles, 70611. T: 337-855-1232. Deacon BRIAN SOLEAU, Dir.
Camp Karol of Saint Charles Center—1087 Boon Rd., Lake Charles, 70611. T: 337-855-1232.
Sea, Apostleship of the Very Rev. RUMBLE P. TOLENTINO, Chap. Deacon PATRICK LAPOINT, Dir., 160 Marine St., Lake Charles, 70601. T: 337-436-1315.
Catholic Charities—1235 Second St., Lake Charles,

70601. T: 337-439-7436. Sr. MIRIAM MACLEAN, R.S.M., Dir.
Pastoral Services, Catholic—1225 Second St., Lake Charles, 70601. Sr. MIRIAM MACLEAN, R.S.M., Sec.
Scouting—617 W. Claude St., Lake Charles, 70605.
 Rev. SAM ANGE III, Chap.
Vocation Director—Rev. JEFFERY PAUL STAMKOVICH.
Vocation Recruiter: Rev. NATHAN LONG.

CLERGY, PARISHES, MISSIONS AND PAROCHIAL SCHOOLS

LAKE CHARLES

(CALCASIEU PARISH)
 1—IMMACULATE CONCEPTION CATHEDRAL (1869) (CEM)
 Mailing Address: P.O. Box 1029, 70602.
 T: 337-436-7251; F: 337-436-7240.
 icathedral@structurex.net;
 immaculateconceptioncathedral.com. Very Rev. RUMBLE P. Tolentino, rumble.tolentino@diocese.org; Rev. Samuel E. Bond, Parochial Vicar; Deacon Christopher Fontenot. Church: 936 Bilbo, 70601.
School—Immaculate Conception Cathedral School, (Grades PreK-8), 1536 Ryan St., 70601.
 T: 337-433-3497; F: 337-433-5056;
 rvia@iccschool.org; www.iccschool.org. Mrs. Christi Jarreau, Prin.; Ms. Tenia Fuselier, Librarian. Teachers (Lay): 36. Students 405.
 2—CHRIST THE KING (2002)
 7680 Gulf Hwy., 70605. T: 337-478-0213;
 www.catholic.org. Very Rev. Rojo Palatty Koonathan, H.G.N.
Catechesis Religious Program—JoAnna Bearb, D.R.E. (Elementary); Tammy Duhon, D.R.E. (Jr. High & Sr. High); Students 103.
 3—ST. HENRY (1958) (MC)
 1021 8th Ave., 70601. T: 337-438-7223.
 pkittling@sthenry.church; www.sthenry.church.
 Very Rev. Matthew Cormier; Rev. Joseph C. Caraway, Parochial Vicar; Deacons Josue Canelo; Patrick Hebert.
Catechesis Religious Program—pkittling@sthenry.church. Phyllis Kittling, D.R.E. Students 32.
 4—IMMACULATE HEART OF MARY (1953) (African American)
 2031 Opelousas St., 70601. T: 337-438-8093;
 F: 337-436-5033; ihmc@uudenlink.net;
 ihmp.wccnconnect.com. Revs. V. Wayne LeBlau; Joby Kamiyamparambil Mathew, H.G.N. In Res.
Catechesis Religious Program—Jacqueline Mathews, D.R.E. Students 120.
Mission—Our Lady of Fatima Chapel, 1700 Graham St., Calcasieu Parish 70601.
 5—ST. MARGARET (1940)
 2500 Enterprise Blvd., 70601. T: 337-439-4585.
 info@stmargaret.church; www.stmargaret.church.
 Revs. Nathan Long; Samuel Orsot; Deacons Raymond Menard; Anthony Fousson.
School—St. Margaret School, (Grades PreK-8), T: 337-436-7959; F: 337-436-9932. Teachers (Lay): 27; Students 285.
Catechesis Religious Program—T: 337-436-6358.
 Joanne Schwem, D.R.E. Students 59.
 6—ST. MARTIN DEFOURIES (2002)
 5495 Elliott Rd., 70605. www.smdpcatholic.com.
 5383 Elliott Rd., 70605. Rev. Msgr. Jace F. Eskind, J.C.L.; Deacon Richard E. Donahoe.
 Res.: 2503 Vogue Dr., 70605. T: 337-478-3845;
 info@smdpcatholic.com.
Catechesis Religious Program—Mrs. Denise Donahoe, D.R.E. Students 215.
 7—OUR LADY OF GOOD COUNSEL (1957)
 221 Aqua Dr., 70605. T: 337-477-1434;
 paul.jussen@diocese.org. Rev. Paul Jussen, M.S.; Sr. Shirley Gobert, S.E.C., Pastoral Assoc.; Deacon Paul Gregory.
 Res.: 221 Aqua Dr., 70605. T: 337-477-1434;
 nathan.long@diocese.org.
Catechesis Religious Program—Students 77.
 8—OUR LADY QUEEN OF HEAVEN (1957) (CEM)
 617 W. Claude St., 70605. T: 337-477-1236;
 OLQH@diocese.org. ulqh.org. Rev. Msgr. Daniel A. Torres, V.G.; Rev. Levi J. Thompson, Parochial Vicar; Deacons George K. Carr, (Retired); Harold Nixon; Brian Kirk; Rev. Charles Okorougo, In Res.; Very Rev. Ruben Villarreal, Ph.D., J.C.L. In Res.
School—Our Lady Queen of Heaven School, (Grades PreK-8), 3908 Creole St., 70605. T: 337-477-7349;
 F: 337-477-7384. Ms. JoAnn Wallwork, Prin.; Diane Oden, Librarian. Teachers (Lay): 65; Students 648.
Catechesis Religious Program—3909 Creole St., 70605. T: 337-477-3937. Pamela Alston, D.R.E. (Grades 7-12); Mrs. Robin Saire, D.R.E. (Grades 1-6). Students 406.
 9—SACRED HEART OF JESUS (1919) (CEM) (African American)
 1102 Mill St., 70601. T: 337-439-2046;
 F: 337-439-2650;

Sacredheart-165uddenlinkmail.com. Rev. Richard U. Adinkwu; Deacons Ed Lavine; Errol DeVillo.
Catechesis Religious Program—Barbara Batiste, D.R.E. Students 53.
 10—ST. THEODORE (1974)
 Mailing Address: 785 Sam Houston Jones Pkwy., 70611. T: 337-855-6662;
 sttheodorecommunity@yahoo.com;
 mossbluffcatholic.org. P.O. Box 12728, 70612. Very Rev. Aubrey V. Guilbeau; Rev. Andrew M. DeRauven, Parochial Vicar; Deacon Leo Anthony Hebert. Res.: 413 Longleaf Dr., 70611.
Catechesis Religious Program—theodorecd@yahoo.com. Sherry Livingston, D.R.E. Students 482.

OUTSIDE THE CITY OF LAKE CHARLES

BELL CITY, CALCASIEU PARISH, ST. JOHN VIANNEY (1939) (CEM)
 7120 Hwy. 14 E., Bell City, 70630. T: 337-358-2502;
 T: 337-358-2504; stjohnvianney1939@yahoo.com;
 stjohnvianney@gmail.com; www.sjv-bc.com. Rev. John Payne, J.C.L.
Catechesis Religious Program—7128 Hwy 14 E., Bell City, 70630. Paige Myers, D.R.E. Students 219.
 BIG LAKE, CAMERON PARISH, ST. MARY OF THE LAKE (1938) Rev. Msgr. James M. Gaddy.
 Res.: 11054 Hwy. 384 (Big Lake), 70607.
 T: 337-598-3101; stmarysla@aol.com.
Catechesis Religious Program—Felisha Nunez, D.R.E. Students 200.
Mission—St. Patrick's, Sweet Lake, Cameron Parish.
 CAMERON, CAMERON PARISH, OUR LADY STAR OF THE SEA (1961)
 135 Our Lady Rd., Cameron, 70631. T: 337-542-4795;
 sacredheartchurch@camtel.net. 5250 W. Creole Hwy., Cameron, 70631. Rev. D.B. Thompson, J.C.L., M.A., M.Div., S.T.B.
Catechesis Religious Program—(Combined with Sacred Heart of Jesus, Creole).
 CREOLE, CAMERON PARISH, SACRED HEART OF JESUS (1890) (CEM) 31 Rev. D.B. Thompson, J.C.L., M.A., M.Div., S.T.B.
 Church & Res.: 5250 W. Creole Hwy., Cameron, 70631. T: 337-542-4795; sacredheart@camtel.net.
Catechesis Religious Program—stephanedridrige@gmail.com. Stephanie Rodrigue, D.R.E. Students 87.
 DEQUINCY, CALCASIEU PARISH, OUR LADY OF LA SALETTE (1955)
 203 S. Grand, DeQuincy, 70633. T: 337-786-3500;
 laalette@dequincy.com; oldq.com. Rev. Luis Tigga, H.G.N.
Catechesis Religious Program—Mark Peloquin, Students 64.
 DE RIDDER, BEAUREGARD PARISH, ST. JOSEPH'S (1938)
 1125 Blankenship Dr., De Ridder, 70634.
 T: 337-463-6878; stjosephsdrider.org. Rev. Jude Brunnett, M.S.; Deacon Al Weinzig.
Catechesis Religious Program—Mrs. Theresa Pendley, D.R.E. Students 175.
 ELTON, JEFFERSON DAVIS PARISH (African American)
 209 Al Woods St., P.O. Box 789, Elton, 70532.
 T: 337-584-2818; jerish.george@diocese.org. Rev. Jose Vattakunnel, M.C.
Catechesis Religious Program—(combined with St. Paul's religious program) Lezlie LaFosse, D.R.E. Students 165.
 2—ST. PAUL (1913) (CEM)
 Mailing Address: P.O. Box 129, Elton, 70532. 1100 St. Mary St., Elton, 70532. T: 337-584-2818.
 stpaul-elton@hotmail.com. Rev. Jose Vattakunnel, M.C.; Deacon Michael Paul Guillory.
Catechesis Religious Program—stpaul-elton@hotmail.com. Lezlie LaFosse, D.R.E. Students 165.
 FENTON, JEFFERSON DAVIS PARISH, ST. CHARLES BORROMEO (1980)
 804 Third Ave., P.O. Box 309, Fenton, 70640.
 T: 337-756-2529; stcharles02@yahoo.com. Rev. Jon Joseph, H.G.N.
Catechesis Religious Program—sccbed@gmail.com. Susan Augustine, D.R.E. Students 57.
Mission—St. John the Evangelist, 306 Ann St., P.O. Box 124, Lacassine, Jefferson Davis Parish 70550.
 T: 337-588-4606; stjohndiacassine@gmail.com. Very Rev. Rojo Palatty Koonathan, H.G.N., Pastor.
Catechesis Religious Program—

stjohnediacassine@gmail.com. Cindy Scharff, D.R.E. Students 156.
 GRAND CHENIER, CAMERON PARISH, ST. EUGENE (1962) (CEM) 31
 5035 Grand Chenier Hwy., Grand Chenier, 70643.
 T: 337-538-2245; stougenc@camtel.net. Rev. Clyde Thomas.
Catechesis Religious Program—Shari Richard, D.R.E. Students 6.
 HACKBERRY, CAMERON PARISH, ST. PETER THE APOSTLE (1955) (CEM) Rev. Arvid Minz.
 Res.: 1210 Main St., P.O. Box 372, Hackberry, 70645.
 T: 337-782-3365; stpeterschurch@camtel.net.
Catechesis Religious Program—Tammy Welch, D.R.E.; Trisha Savoie, D.R.E. Students 82.
Mission—Our Lady of the Assumption, 6470 Gulf Beach Hwy., Johnsons Bayou, 70631.
Catechesis Religious Program—Cherylene Sanditer, D.R.E.; Cindy McGee, D.R.E. Students 28.
 IOWA, CALCASIEU PARISH, ST. RAPHAEL (1931)
 Mailing Address: 213 S. Thomson Ave., P.O. Drawer 849, Iowa, 70647. T: 337-582-3503;
 straphael-iowa@hotmail.com. Rev. Anthony M. Fontenot.
 Res.: 918 Dorothy St., P.O. Drawer 849, Iowa, 70647.
Catechesis Religious Program—Brittany Foreman, D.R.E. Students 223.
Mission—St. Joseph.
 JENNINGS, JEFFERSON DAVIS PARISH (1956)
 515 Bryan St., Jennings, 70546. T: 337-824-1164;
 icchurchjennings@yahoo.com; icchurchjennings.com.
 Rev. Marion Susil Fernando.
Catechesis Religious Program—icchurchjennings@yahoo.com. Students 51.
 2—OUR LADY HELP OF CHRISTIANS (1891) (CEM)
 710 State St., P.O. Drawer 1170, Jennings, 70546.
 T: 337-824-0168; secretary@olhcjennings.com;
 olhcjennings.com. Very Rev. Keith Pellerin; Rev. Trey Ange, Parochial Vicar.
School—Our Lady Help of Christians School, 600 Roberts Ave., Jennings, 70546. T: 337-824-1743;
 F: 337-824-1752; rchapman@olhcjennings.com. Rebecca Chapman, Prin. Teachers (Lay): 25; Students 237.
Catechesis Religious Program—Melody Trahan, D.R.E. (PreK-8th); Debbie Davis, D.R.E. (PreK-8th). Students 208.
 3—OUR LADY OF PERPETUAL HELP (1941) (CEM)
 920 S. Broadway, P.O. Box 1331, Jennings, 70546.
 T: 337-824-3182; F: 337-824-3186.
 olphjennings@att.net. Rev. Jude Fernando, T.O.R.
Catechesis Religious Program—T: 337-824-3703, Ella Dartest-Williams, D.R.E. Students 28.
 KINDER, ALLEN PARISH, ST. PHILIP NERI (1937) (CEM) (Acadian—French)
 607 4th Ave., P.O. Box 146, Kinder, 70648.
 T: 337-738-5612; whitney.miller@diocese.org;
 www.spenichurch.com. Rev. Whitney Miller; Deacon Roy Nash.
Catechesis Religious Program—317 7th St., P.O. Box 146, Kinder, 70648. T: 337-738-5635;
 stphilipneri@centurytel.net. Laurie Pickle, D.R.E. Students 221.
 LAKE ARTHUR, JEFFERSON DAVIS PARISH, OUR LADY OF THE LAKE (1922) (CEM) (JC3) Rev. Jay Alecius.
 Res.: 303 Commercial Ave., Lake Arthur, 70549.
 T: 337-774-2614; F: 337-774-3793.
 olbsecretary@bellsouth.net;
 www.ourladyofthelake.church.
 OAKDALE, ALLEN PARISH, SACRED HEART (1948) (CEM)
 1208 7th Ave., Oakdale, 71463-0926, P.O. Box 926, Oakdale, 71463. Rev. Vijaya Reddolu, H.G.N.
Catechesis Religious Program—Diane Bacon, D.R.E. Students 60.
Mission—St. Frances, 204 Poplar St., P.O. Box 926, Elizabeth, Allen Parish 70638.
 OBERLIN, ALLEN PARISH, ST. JOAN OF ARC (1920) (CEM)
 110 W. Fifth Ave., P.O. Box 479, Oberlin, 70555.
 T: 337-639-4399; secretary@sjoaoberlin.com;
 sjoaoberlin.com. Rev. Jerish George; Deacons Norris Chapman, (Retired); James Dale Deshotel.
Catechesis Religious Program—Students 88.
 RAGLEY, BEAUREGARD PARISH, ST. PIUS X CATHOLIC CHURCH (2014)
 16816 Hwy. 171, Ragley, 70657. T: 337-725-3719;
 F: 337-725-6248; secretary@spix.church;

CATHOLIC CHURCH IN THE U.S.

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LAKE CHARLES (LKC)

bookkeeper@spx.church, spx.church. Rev. Jeffery Paul Starkovich.
Catechesis Religious Program—
 stpiusred@centurytel.net. Students 151.
 RAYMOND, JEFFERSON DAVIS PARISH, ST. LAWRENCE (1951) Rev. William Miller.
 Res.: 5505 Pine Island Hwy., Jennings, 70546.
 T: 337-584-2700; F: 337-584-3990;
 stlawrence@yahoo.com.
Catechesis Religious Program—T: 337-584-2002;
 F: 337-584-3990. Students 174.
 SULPHUR, CALCASIEU PARISH
 1—IMMACULATE CONCEPTION OF THE B.V.M. (1959)
 2700 Maplewood Dr., Sulphur, 70663.
 T: 337-625-3364; church@csulphur.org;
 csulphur.org. Rev. Timothy Goadly; Deacon Chris Gregory.
Catechesis Religious Program—T: 337-527-5261;
 olps6@olpsulphur.com. Paula Hunter, D.R.E. Students 308.
 2—OUR LADY OF LASALETTE (1961) [CEM]
 602 N. Claiborne St., Sulphur, 70663.
 T: 337-527-6722; als@suddenlinkmail.com. Rev. Andrews Kollannoor, M.S. In Res., Rev. Lawrence A. Kohler, M.S.
Catechesis Religious Program—T: 337-527-8307. Cay Gibson, D.R.E. Students 192.
 3—OUR LADY OF PROMPT SUCCOR (1919)
 1109 Cypress St., Sulphur, 70663. T: 337-527-5261;
 olps6@olpsulphur.com; olps16@olpsulphur.com;
 www.olpsulphur.com. Very Rev. Edward J. Richard, M.S.; Rev. Michael Eugene Caraway, Parochial Vicar; Deacon Patrick LaPoint; Msgr. Arthur B. Calkins, In Res.; Rev. Edward J. Brunnert, M.S., In Res. *School—Our Lady's School*, (Grades Pre-K-8), 1111 Cypress St., Sulphur, 70663. T: 337-527-7828; F: 337-528-3778. hdouglas@ourladysschool.org. Hank Douglas, Prin.; Joan Habetz, Treas.; Ms. Stephanie Vinator, Librarian. Teachers (Lay) 15; Students 244.
Catechesis Religious Program—1029 LaSalette Dr., Sulphur, 70663. T: 337-527-9964. Patay Hebert, D.R.E.; Terry Sittig, D.R.E. Students 198.
 4—ST. THERESA (1971)
 4822 Carlyss Dr., Sulphur, 70665. T: 337-583-4800; sttheresa1@camtel.net; st-theresa-parish.org. Revs. Luke Krzanowski; Bino Francis Poovannikunnel, M.S., Parochial Vicar; Deacon Keith Ellender.
Catechesis Religious Program—T: 337-583-4800. Angie Clark, D.R.E. Students 395.
 VINTON, CALCASIEU PARISH, ST. JOSEPH (1920) Rev. Carlos Garcia Cardona; Deacon Jesse Menard. Res.: 1502 Industrial St., Vinton, 70668.
 T: 337-589-7358; stjosephvinton@hotmail.com.
Catechesis Religious Program—Rhonda Guidry, D.R.E. Students 137.
 WOLSH, JEFFERSON DAVIS PARISH
 1—ST. JOSEPH (1941) [C] (African American)
 310 N. Sarah St., Wolsh, 70591. T: 337-434-3673; stjosephwolsh@gmail.com. Rev. Pradeep Gali. *Mission—St. Peter Claver*, 400 W. 2nd St., Iowa, Calcasieu Parish 70547. F: 337-734-4435.

Catechesis Religious Program—Students 7.
 2—OUR LADY OF SEVEN DOLORS (1904) [CEM] [C]
 T: 337-734-3446; alantrouille@gmail.com. Rev. Alan P. Trouille; Deacons Richard Hinchee, Wayne Chapman.
Catechesis Religious Program—Rachelle Trahan, D.R.E. Students 224.
 WESTLAKE, CALCASIEU PARISH, ST. JOHN BOSCO (1955)
 Rev. Joseph Joseph, H.G.N.; Deacons Fred Reed Jr.; Garrett Caraway Jr.; Rev. Michael J. Barras, In Res. Res.: 1301 Sampson St., Westlake, 70669.
 T: 337-433-2467; ccampbell@yahoo.com.
Catechesis Religious Program—bhogan@st.johnsboscchurch.com. Barbara Hogan, D.R.E. Students 280.

Chaplains of Public Institutions

LAKE CHARLES, *Lake Charles Memorial Hospital*. Rev. Benignus Lambertus Wego, S.V.D.
 SULPHUR, *West Calcasieu Cameron Hospital*.

On Leave:

Rev.—
 DesOrmeaux, Scott, P.O. Box 3223, 70602-3223.

Leave of Absence:

Very Rev.—
 Conner, Jacob Scott.
 Rev.—
 Johnson, Marcus.

Retired:

Rev. Msgr.—
 Dubois, Charles J., (Retired), P.O. Box 1924, 70602.
 Revs.—
 Boullet, Marshall, (Retired), 230 Fairway Dr., Crowley, 70526.
 Harris, Whitney G., (Retired), 233 Dogwood Ct., Canton, MI 48187-3971. T: 651-201-1800. Wells Fargo Place, 307th St. E., St. Paul, 55101-7804.
 Mancuso, Henry, (Retired), 568 Kirby St., 70601.
 Marco, Alfredo, (Retired), #9 Std. Domingo St., Bombon, Camarines Sur Philippines.
 T: 011-63-54-471-65-24.
 McGrath, Joseph, (Retired), 605 Willow Springs Rd., Sulphur, 70663.
 Mulanjanany, Augustine, (Retired), 1019A Daoust Dr., Alexandria, 71303.
 Mullen, Thomas G., (Retired), 15115 Interlachen Dr., Unit 712, Silver Spring, MD 20906-5642.
 T: 301-598-1922; waverlywood@earthlink.net.
 Piraro, Don, (Retired), 3905 Kingston St., Box 36, 70605.
 Puerio, John, (Retired), 3905 Kingston St., 70605.
 Sedita, Vincent, (Retired), 4411 Mimicello St., 70605.
 Smit, Gerard C., (Retired), 147 W. State St., Apr. 109, Kennett Square, PA 19348. (Non-Active)

Vaughn, Roland G., (Retired), P.O. Box 231, Lacassine, 70650.

Permanent Deacons:

Bertrand, Glen.
 Bushnell, Joseph.
 Canelo, Josue, St. Henry Catholic Church, Lake Charles.
 Caraway, Julius G. Jr., St. John Bosco Church, Westlake.
 Carr, George K., (Retired), Our Lady Queen of Heaven, LC.
 Chapman, Norris, (Retired).
 Chapman, Wayne, Our Lady of Seven Dolors, Welsh Deshotel, Dale, St. Joan of Arc, Oberlin; (Chairperson).
 DeVille, Errol Joseph, Sacred Heart of Jesus Catholic Church, Lake Charles.
 Donahoe, Richard E., St. Martin de Porres Catholic Church, Lake Charles.
 Ellender, Keith, St. Theresa of the Child Jesus, Carlyss.
 Fontenot, Christopher.
 Gregory, Chris, Immaculate Conception, Sulphur.
 Guillory, Michael Paul, St. Paul Catholic Church, Elton.
 Harmon, Glenn.
 Hebert, Leo Anthony, St. Theodore Catholic Church, Moss Bluff.
 Hebert, Patrick, St. Henry Catholic Church, Lake Charles.
 Hinchee, Richard, Our Lady of Seven Dolors, Welsh.
 Kirk, Brian, Our Lady Queen of Heaven, Lake Charles.
 LaPoint, Patrick, Our Lady of Prompt Succor, Sulphur; (Vice-Chairperson).
 Lavine, Edward, Sacred Heart, Lake Charles.
 McNally, Edward, (Retired), Immaculate Conception, Jennings.
 Menard, Jesse, St. Joseph, Vinton.
 Menard, Raymond, St. Margaret, LC.
 Nash, Roy, St. Philip Neri, Kinder.
 Nixon, Harold, Our Lady Queen of Heaven, Lake Charles.
 Pousson, Anthony, St. Margaret of Scotland, Lake Charles.
 Reed, Frederick, (Retired), St. John Bosco, Westlake.
 Sence, Maurice, (Retired), Our Lady of LaSalette, Sulphur.
 Soileau, Brian, Camp Karol Retreat Center.
 Starr, Stephen, St. Raphael Catholic Church, Iowa, LA.
 Stearns, George, Chancellor & Archivist.
 Tramel, Michael, St. Lawrence, Jennings.
 Wagner, Harry E. Jr., (Retired), Immaculate Conception, Sulphur.
 Wennug, Albert, St. Joseph Catholic Church, DeBiddle.

INSTITUTIONS LOCATED IN DIOCESE

[A] HIGH SCHOOLS, INTERPAROCHIAL
 LAKE CHARLES, *St. Louis Catholic High School*, 1820 Bank St., 70601. T: 337-436-7275; F: 337-436-6792; mcgeron@clchs.org; www.clchs.org. Ms. Mia Orgeron, Admin.; Rev. Nathan Long, Rector; Very Rev. Ruben Villarreal, Ph.D., J.C.L., Chap.; Melanie Lejeune, Librarian. Teachers (Lay) 53; Students 540; Teachers (Priests) 1; Teachers (Sisters) 1.
[B] GENERAL HOSPITALS
 LAKE CHARLES, *CHRISTUS Health Southwestern Louisiana* dba *CHRISTUS Ochsner St. Patrick Hospital* & *CHRISTUS Ochsner Lake Area Hospital*, 524 Dr. Michael DeBakey Dr., 70601.
 T: 337-436-2511; F: 337-491-7157;
joy.hubb@christushealth.org;
www.christushealth.org. Kevin Holland, CEO; Joy Huff, Vice Pres., Mission Integration; Revs. Brian Madison King, Chap.; Charles Okorougo, Chap.; Sr. Leone Iweh, D.M.M.M., Chap. Sponsored by Christus Health System, Irving, TX. Bed Capacity 318, Tot Asst. Annually 229,804; Total Staff 1,249.
[C] RETREAT HOUSES
 LAKE CHARLES, *St. Charles Center*, 2151 Sam Houston Jones Pkwy., 70611. T: 337-855-1232;
 F: 337-855-9062; michelle.moncaux@lkdioocese.org;
www.stcharlescenter.com. Deacon Brian Saleau.
[D] SPECIAL RESIDENCES
 LAKE CHARLES, *Our Lady Queen of Heaven Manor*, Villa Maria, 3905 Kingston St., 70605.
 T: 337-478-4780; F: 337-474-8822;
villamaria@suddenlinkmail.com. Becky See, Dir.

Bed Capacity 118; Tot Asst. Annually 55; Total Staff 33.

[E] NEWMAN CENTERS

LAKE CHARLES, *Catholic Student Center*, McNeese State University, 221 Aqua Dr., 70605.
 T: 337-477-1434; F: 337-479-2129;
paul.jussen@lkdioocese.org;
www.cowboyathletics.com. Rev. Paul Jussen, M.S., Pastor; Sr. Shirley Gobert, S.E.C., Pastoral Assoc.; Deacon Paul Gregory.
Center for Catholic Studies, McNeese State University, 221 Aqua Dr., 70605. T: 337-477-1434.
 F: 337-479-2129; nathan.long@lkdioocese.org. Sr. Marirose Rudek, R.S.M., Dir.

[F] HOUSE OF DISCERNMENT

LAKE CHARLES, *Vianney House of Discernment*, 1824 Bank St., 70601. T: 337-493-5252;
ruben.buller@lkdioocese.org. Very Rev. Ruben J. Buller, V.G., Dir.

[G] SOCIAL SERVICE CENTERS

LAKE CHARLES, *Catholic Charities Southwest Louisiana*, 1225 2nd St., 70601. T: 337-439-7436;
 F: 337-439-7435; jessica.watson@lkdioocese.org. Sr. Miriam MacLean, R.S.M., Dir. Tot Asst. Annually 133,999; Total Staff 4.

[H] MISCELLANEOUS

LAKE CHARLES, *Catholic Daughters of America*, 7506 Cardiff Ave., Baton Rouge, 70808. T: 225-769-0122; conniecd@yahoo.com. Very Rev. Edward J. Richard, M.S., Chap.
CHRISTUS St. Patrick Foundation dba *CHRISTUS Ochsner Southwestern Louisiana Foundation*, 524

Doctor Michael DeBakey Dr., 70601.
 T: 337-430-5353; F: 337-430-5352;
kay.barneitt@christushealth.org;
www.christushealth.org. Kay Barneitt, Exec.
CHRISTUS St. Patrick Home Care, T: 337-395-5600;
laurie.jones2@hcgroupp.com. Deloris Parnell, Regl. Admin.
School Food Services of Lake Charles, Inc., 1112 Bilbo St., 70601. T: 337-433-9640, Ext. 202;
 F: 337-433-9685; edrie.durio@lkdioocese.org. Edrie Durio, Dir.
Society of Roman Catholic Church of the Dioceses of Lake Charles, 414 Iris St., 70601. T: 337-439-7400;
daniel.torres@lkdioocese.org; www.lkdioocese.org.
 P.O. Box 3223, 70602-3223. Rev. Msgr. Daniel A. Torres, V.G., Vicar Gen.; Very Rev. Ruben Villarreal, Ph.D., J.C.L., Vice Chancellor; Deacon George Stearns, Chancellor; Very Revs. Ruben J. Buller, V.G., Moderator; Aubrey V. Guilbeau, Vicar.
JENNINGS Magnificat Lake Charles Chapter Inc., 18057 D.A. LeDoux Rd., Jennings, 70546.
 T: 337-246-0625. Sharla H. Prejan, Coord.
 SULPHUR, *SAINT FRANCIS DE SALES ORATORY*, 602 Huntington St., Sulphur, 70663.
RELIGIOUS INSTITUTES OF MEN REPRESENTED IN THE DIOCESE
 For further details refer to the corresponding bracketed number in the Religious Institutes of Men or Women section.
 [1]—*The Herald of Good News* (Odisha, India)—H.G.N.
 [1]—*Institute of Christ the King Sovereign Priest*.
 [1]—*Missionaries of Compassion* (Andhra Pradesh, India)—M.C.
 [0720]—*The Missionaries of Our Lady of La Salette* (Hartford, CT)—M.S.

{}—*Society of the Divine Word* (Bay Saint Louis, MS)—
S.V.D.
RELIGIOUS INSTITUTES OF WOMEN
REPRESENTED IN THE DIOCESE
[0470]—*Congregation of the Sisters of Charity of the
Incarnate Word, Houston, Texas*—CCVI.

{}—*Daughters of Mary, Mother of Mercy* (Prov. of
U.S.A./Canada)—D.M.M.M.
{}—*Religious Sisters of Mercy of Alma* (Alma, MI)—
R.S.M.

NECROLOGY
† O'roth, Ronald, (Retired), Died May 10, 2020

An asterisk (*) denotes an organization that has established tax-exempt status directly with the IRS and is not covered by the USCCB Group Ruling.

<https://digital.officialcatholicdirectory.com/publication/?m=66509&i=712281&p=1&ver=html5>

5/5

SECTION V

MISCELLANEOUS

SECTION M

DIOCESAN PERSONNEL POLICY

DIOCESE OF LAKE CHARLES

DIOCESAN EMPLOYEE POLICY AND GUIDELINES

FISCAL YEAR 2018-2019

REVISION DATE: 07-01-18

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INTRODUCTION

This policy is intended to reflect the current practices in regard to employees of the Diocese of Lake Charles. It is intended to serve as a guide and in no way to be considered as a contract of employment. Except as otherwise noted in a contract, all employment is at-will. The Diocese of Lake Charles reserves the right to change its personnel practices and to modify this policy at any time.

EMPLOYMENT POLICIES

EQUAL OPPORTUNITY

As an organization, which concerns itself with the mission and ministry of Christ's Church, the Catholic Diocese of Lake Charles will always strive to set an example for others in the matters of equal employment opportunities.

In practicing social justice it is the policy of the Diocese to treat all employees and applicants according to their individual qualifications, ability, experience, and other employment standards without regard to race, color, gender, age, national origin or disability, marital or veteran status. This applies to all work relationships, including recruitment, selection, placement and promotion.

Because of its unique purpose and mission, the Diocese does reserve the right to employ, within applicable civil and ecclesiastical laws, individuals who share the Church's beliefs.

OFFICE HOURS

Except for supervisory employees the office hours for diocesan employees will be 8:30 a.m. to 4:30 p.m. Monday through Friday. Employees will be allowed a total of one hour per day for lunch and break periods. Employees may divide the hour between lunch and break periods, or use the entire hour for lunch. Employees should schedule their lunch and break periods in consultation with the Office Director to ensure adequate coverage of their office.

Supervisory employees of the Diocese do not have a specific time schedule to follow. Supervisory employees will follow a time schedule best suited to fulfill their duties. Whenever out of the office, with the approval of their Department Secretary, Supervisory employees are to ensure that their Administrative Assistants are present to provide adequate coverage of their office from 8:30 A.M. to 4:30 P.M., Monday thru Friday.

CLASSIFICATION OF EMPLOYEES

The Fair Labor Standards Act (FLSA) requires that non-exempt employees be paid at one and one-half (1 ½) times regular pay for all hours worked over forty hours (40) in a week. For purposes of this regulation, the following definitions apply:

Executive, Supervisory, Administrative and Professional employees are considered exempt under the FLSA and are not paid overtime.

Support Staff, Clerical, and Domestic /Maintenance employees are not exempt from the FLSA and are paid overtime at the rate of one and one-half (1½) times their hourly rate for any work performed in excess of forty (40) hours per week. The Department Secretary must approve any overtime.

All new employees of the diocesan offices are hired on a provisional basis; that is everyone is subject to a three- (3) month probationary period. During this time the employee's supervisor will observe the employee's performance, attitude, and learning ability, and competence for the employee's job. Employees are expected to acquaint themselves with the diocese and their work assignment during this same period.

As the probationary period is considered a time of evaluation, an employee may terminate his/her employment or be terminated by management at any time during this period. If this occurs it is regarded as exploratory and without cause or derogatory effect to his/her record.

Eligibility for employee benefits will be governed by the employee's classification of employment and work arrangement as defined below.

Regular Full-time: An employee who works 35 to 40 hours per week.

Regular Part-time: An employee who works 30 to 35 hours per week.

The Diocese considers the fiscal year to be from July 1-June 30th, and uses this time as a guide for eligibility on benefits given. Employees in each category (regular part-time and regular full-time) are entitled to share in the following benefits provided by the Diocese.

Health Insurance
Retirement Plan
Sick Leave
Personal Days
Vacation
Holidays

BENEFITS

HEALTH INSURANCE

The Insurance premiums are paid by the Diocese to cover eligible employees. Consult the current policy booklet to determine the starting coverage.

RETIREMENT PLAN

Upon employment, each employee may enroll in the Diocesan Plan at a minimum participation of 1% of gross wages, to be deducted from the semi-monthly and/or monthly salary. The Diocesan contribution is 1.5% of gross wages.

SICK LEAVE

From the commencement of employment, sick leave shall accrue at ten (10) days per fiscal year. Sick leave is allowed for personal illness by regular full time and regular part-time employees. Unused sick days may be accumulated from year to year up to maximum of thirty (30) working days. Upon termination of employment for any reason, the employee shall not be entitled to any compensation for accumulated sick leave.

Sick leave benefits do not and shall not create a right of the employee for money or any other benefits.

These days can be combined with (FMLA) at the discretion of the Diocese.

FAMILY AND MEDICAL LEAVE ACT OF'93 (FMLA)

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

*See attached, "Schedule A" Your Rights Under the Family and Medical Leave Act of 1993 Revised 2013

PERSONAL LEAVE

Following a probationary 3-month period each employee is allowed (2) personal days during the fiscal year. While the list is not exhaustive, personal days could be for family sickness, funerals, and family business and other unavoidable personal reasons. Unused personal days do not accumulate from year to year.

HOLIDAYS

*See attached "Schedule B"

VACATION

Following a probationary 3-month period, all new regular, full-time employees (35-40 Hours per week) are entitled to vacation days. Following the beginning of the next fiscal year after the provisional period, vacation benefits for Full-time employees is as follows:

Employed up to 10 years as of July 1st: 10 working days per year.

Employed 10 years or more as of July 1st: 15 working days per year.

Vacation benefits for regular part-time employees (less than 35-hrs. per week) are calculated in the proportion that working hours have to 35 hours.

All vacation days must be taken by June 30 of the fiscal year following the fiscal year in which they were earned. Normally, no more than three weeks of vacation may be taken at one time. Unused vacation days may only be accrued for the previous Fiscal Year only. Payment is not made for vacation days not taken. No less than a full day may be used at a time. The appropriate Office Director must approve vacation time in advance to ensure that offices are properly maintained and staffed.

JURY DUTY

Employees are to notify their supervisor immediately upon receipt of a summons so that arrangements can be made for their absence from work. Employees will receive their regular pay while they are serving on jury duty. To receive this pay employees must provide a written statement from the court showing those days served. This benefit is also extended to an employee who is subpoenaed to serve as a witness in a court of law in a non-family, non-personal matter.

PAY

Employees shall be paid twice a month-on the 15th and the 30th of each month. If a payday falls on a weekend employees are paid the Friday before. If it falls on a company-observed holiday, employees will be paid the workday before the holiday.

Employees shall be paid for all regularly scheduled hours through payday. If the employee is non-exempt, there may be times when pay will need to be adjusted:

- if employee works more or less than scheduled hours
- if employee works overtime
- if employee misses work

Adjustments are made after FISCAL receives employees time sheet for processing.

SOCIAL SECURITY (FICA)/MEDICARE

The Diocese is obligated by Internal Revenue Laws to withhold Social Security and Medicare from all wages. The current withholding rate is 7.65% paid by the Diocese. The employee's portion is 7.65% and is deducted from their check.

CONDUCT AND CONFIDENTIALITY

DRESS CODE AND BEHAVIOR

Employees of the Diocese of Lake Charles are expected to use good judgment in grooming, personal hygiene and dress and to behave in a professional and business-like manner, in accordance with the values of the Catholic Church.

*See attached "Schedule C"

CONFIDENTIALITY

As part of the job, the employee may have access to confidential information and proprietary property, which the employee should not share with any individual except on a need to know basis. Confidential information includes by way of illustration, but not limited to.

- employees' salaries, benefits, performance, disciplinary and similar private information
- administrative procedures and manuals
- business and financial plans
- computer programs
- accounts receivable lists and financial information
- vendor contracts

WORKING WITH RELATIVES

This policy shall be effective July 1, 2008 and shall not affect any current relationships.

Diocese of Lake Charles selects employees based on their job qualifications. To make sure this standard is always followed and to protect the integrity of business operations, the Diocese has certain restrictions on when and where relatives of employees can be hired and how related employees can work together.

Who is a relative?

Members of your immediate family-including your spouse, parents, siblings and children are considered your relatives. Relatives also include persons related by marriage (including in-laws) and those related by law (including adoption, guardianship and foster parent relationships).

Two employees may also be considered related if they have a personal relationship that, in the opinion of the company may affect or give the appearance of affecting the employment decisions of the manager or supervisor. A personal relationship may include a dating relationship, or a relationship between managers or supervisors and any of their direct or indirect reports involving a shared residence.

Employment guidelines

Relatives will not be hired, promoted or transferred to positions that:

- Place them in the same department.
- Place them in a direct or indirect supervisory or managerial capacity over a relative.
- Allow them to directly or indirectly influence performance appraisals, salary adjustments, career progress or other managerial activities involving the relative.
- Require them to audit or review the work of another relative.
- Place them at opposite ends of a transaction or situation. It is important that transactions always be handled at "arm's length." For example, if a member of your family or someone with whom you have a close relationship wants to do business or is doing business with the Diocese, you must direct that relative to another employee for assistance and not attempt to influence the outcome of the decision in any way.

TALKING TO THE MEDIA

If an employee is contacted by a news reporter, he or she should refrain from answering questions or responding to requests for information about the Diocese of Lake

Charles. Refer all media calls to the Bishop, the Vicar General or the Diocesan Spokesperson.

SMOKING POLICY

The Diocese of Lake Charles is a smoke free workplace. No smoking is allowed within the buildings. Employees who wish to smoke may do so in the designated outside areas.

OTHER ITEMS OF IMPORTANCE

GRIEVANCE PROCEDURE

An employee with a grievance should discuss it with the immediate supervisor. Should this step not provide a satisfactory resolution of the grievance within 5 days of the discussion with the supervisor, the employee can request a review of the alleged grievance by his or her Office Director. Within 5 days of full receipt of the employee's request for review of the grievance, the Office Director shall act on the grievance.

If no solution or satisfactory response is made within 5 days and the employee wishes to pursue the matter further, a formal written grievance can be filed with the Moderator of the Curia. Upon receipt of this written grievance, a formal committee may be established by the Moderator of the Curia to hear the complaint within 10 days of receipt of the grievance. The committee shall come to a resolution within 10 days.

An employee filing a grievance is acting fully within his or her rights. No reprisals of any kind shall be taken against an employee as a result of filing a grievance. A grievance may be withdrawn at any level without prejudice or record.

SEXUAL HARASSMENT

It is the Diocese's policy to provide employees with a workplace free from sexual harassment. Sexual

harassment is a violation of Title VII of the Civil Rights Act of 1964, as amended and the Diocese will not permit any employee, male or female, to sexually harass another employee in any way. Sexual harassment may involve, but is not limited to:

Making as a condition of an employee's continued employment, unwelcome sexual advances or request for sexual favors or other verbal or physical conduct of a sexual nature.

Making submission to or rejection of such conduct the basis for employment decisions affecting the employee.

Creating an intimidating, hostile, or offensive working environment by such conduct.

Sexual harassment refers to behavior that is not welcome, that is personally offensive, which fails to respect the rights of others, that lowers morale and that, therefore, interferes with our work effectiveness. Sexual harassment may take different forms. One specific form is the demand for sexual favors. Other forms of harassment include but are not limited to:

Verbal: Sexual innuendoes, suggestive comments, and jokes of a sexual nature, sexual propositions, and threats.

Non-verbal: Sexually suggestive objects or pictures, graphic commentaries, suggestive or insulting sounds, leering, whistling, obscene gestures.

Physical: Unwanted physical contact, including touching, pinching, brushing the body, pushing.

Whatever form it takes, sexual harassment is insulting and demeaning to the recipient and will not be tolerated in the workplace. All employees, managers and non-supervisors alike, must comply with this policy and take appropriate measures to ensure that such conduct does not occur. Violations of this policy may result in disciplinary action up to and including termination.

Employees who believe that they have been subjected to sexual harassment should immediately report the matter to their immediate supervisor or Department Secretariat so that steps can be taken to stop the harassment. No retaliatory measures will be taken against any employee who complains of sexual harassment. Under no circumstances need the employee report the harassment to a supervisor who is the person accused of sexual harassment. The employee may bypass the supervisor to the next higher level of supervision.

The Diocese will, to the maximum extent feasible, maintain the confidentiality of such complaints on a need-to-know basis. However, investigation of such complaints will generally require disclosure to the accused party and other witnesses in order to gather pertinent facts.

SAFETY

The Diocese strives to provide a safe working environment. It is the responsibility of each employee to do his or her part in following safety procedures and guidelines. Each employee is expected to inform the immediate supervisor of any unsafe condition upon becoming aware of it.

If an employee is involved in a work-related accident, or witnesses someone else's injuries, it is his or her responsibility to report it to a supervisor immediately. If emergency care is needed the proper authority such as 911, police, fire, EMS or other appropriate agency (Police, Fire, EMS) should be called. Anyone injured on the job should seek medical attention immediately.

WORKERS' COMPENSATION

All employees of the diocese are covered by worker's compensation insurance, which provides coverage for occupational illness and injury. The program is administered in accordance with the State of

Louisiana's Worker's Compensation laws and all applicable federal regulations.

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

BENEFITS & PROTECTIONS

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division



Holidays

2018-2019

| | | | | |
|-----------|-----------|----|------|---------------------------------------|
| Wednesday | July | 4 | 2018 | Independence Day |
| Wednesday | August | 15 | 2018 | Assumption of the Blessed Virgin Mary |
| Monday | September | 3 | 2018 | Labor Day |
| Thursday | November | 1 | 2018 | All Saints Day |
| Thursday | November | 22 | 2018 | Thanksgiving Day |
| Friday | November | 23 | 2018 | Thanksgiving Friday |
| Friday | December | 21 | 2018 | Christmas Break |
| Monday | December | 24 | 2018 | " " |
| Tuesday | December | 25 | 2018 | " " |
| Wednesday | December | 26 | 2018 | " " |
| Thursday | December | 27 | 2018 | " " |
| Friday | December | 28 | 2018 | " " |
| Monday | December | 31 | 2018 | " " |
| Tuesday | January | 1 | 2019 | " " |
| Monday | January | 21 | 2019 | Martin Luther King, Jr. Day |
| Monday | March | 4 | 2019 | Mardi Gras |
| Tuesday | March | 5 | 2019 | Mardi Gras |
| Thursday | April | 18 | 2019 | Holy Thursday |
| Friday | April | 19 | 2019 | Good Friday |
| Monday | April | 22 | 2019 | Easter Monday |
| Monday | May | 27 | 2019 | Memorial Day |

***** Personal Birthday

Dates to Remember:

| | | |
|-----------------|----|-----------------------------------|
| Sunday November | 4 | 2018 Daylight Savings Time Ends |
| Sunday March | 10 | 2019 Daylight Savings Time Begins |

Schedule C

Diocese of Lake Charles Dress Code Policy

Our objective is to allow employees and volunteers to work comfortably while at the same time projecting an acceptable image of our diocese to the public. As people called by God to worship Him and praise His great name, we seek to create a work environment that encourages professionalism, mutual courtesy and respect and that promotes personal spiritual growth and development. We want the workplace to project a visible image of our Catholic Christian beliefs, traditions, and values. We are attempting to promote a sensitivity that naturally surfaces from an environment which is respectful of the work of ministry and requires decorum of dignity for Jesus Christ, whom we serve. For that reason, no one's outward appearance should become a distraction to the peace of mind of others in the workplace and in ministry.

GENERAL GUIDELINES

- Each individual is expected to be aware of and conscientious about his/her personal hygiene, neatness of attire and cleanliness of apparel.
- Hair should be clean, combed, and neatly trimmed or arranged as should sideburns, moustaches and beards.
- Visible tattoos and body piercing other than earrings are not acceptable.
- Strong odors or excessive use of perfumes or colognes should be avoided as a courtesy to those who may have sensitivities or allergies.

No dress code can cover all contingencies so one must exert a certain amount of prudence in choosing clothing for work. Anyone experiencing uncertainty about acceptable attire for work should ask his/her supervisor or a designated dress code person, if there is one.

Because not all clothing is suitable for the office, these guidelines will assist in determining what is appropriate to wear to work. Clothing that works well for the beach, yard work, dance clubs, exercise sessions, and sports contests would not be appropriate for a professional appearance at work.

- Clothes should be proper fitting and good condition. Clothing that is too tight and form fitting or that reveals too much cleavage, back, chest, stomach or underwear is not appropriate for the office.
- Clothing should be pressed and never wrinkled. Torn, dirty, or frayed clothing is unacceptable. All seams must be finished.
- Any clothing that has words, terms, or pictures is inappropriate.
- Clothing that poses a threat to the safety of self or others, results in a productivity issue or the inability to perform a certain job task or that could result in complaints is inappropriate.
- When functioning in an official capacity men should wear a coat and tie.

BOTTOMS

- **Appropriate:** Slacks that are similar to Dockers and other makers of cotton or synthetic material pants, wool pants, flannel pants, dressy capris, and nice looking dress synthetic pants are acceptable. Skirt and dress length that allow one to sit comfortably.
- **Inappropriate:** Denim of any color; sweatpants, exercise pants, Bermuda shorts; short shorts, bib overalls, cargo pants, nylon jogging pants or suits, and any spandex or other form-fitting pants such as those worn for biking or other sporting activities, miniskirts or split skirts that ride halfway up the thigh.

TOPS

- **Appropriate:** Long or short sleeved dresses, blouses, dress shirts, sweaters, tops, knit tops and turtlenecks. Sleeveless tops and dresses are only appropriate when the fit does not reveal undergarments and the under arm areas and should be worn under a jacket or in a layered fashion.
- **Inappropriate:** Denim of any color, sweatshirts, t-shirts, tank tops (unless under a jacket), halter tops, low cut tops or midriff shirts, sheer tops, strapless or spaghetti-strap tops or dresses, sun or beach dresses. Sports team and university names on clothing are not allowed.

SHOES AND FOOTWEAR

- **Appropriate:** Conservative walking shoes, dress shoes, oxfords, loafers, boots, flats, pumps, dress heels, sandals and mules or open back shoes. Hosiery is not required but is encouraged when appropriate.
- **Inappropriate:** Athletic shoes, tennis shoes, thongs, flip-flops, slippers, and any other plastic type shoes that are intended for leisure activities.

ACCESSORIES

- **Appropriate:** Scarves, ties, belts, conservative jewelry and makeup.
- **Inappropriate:** Baseball caps, skull caps, bandanas.

EXCEPTIONS

There are some job tasks that require a departure from guidelines, such as grounds keepers, food preparers, etc. Those exceptions will be addressed within each secretariat and clearly outlined for each exception.

There may be occasions when exceptions are made by administrators or supervisors for observance of particular celebrations, activities or events.

PROCEDURE

The Secretary of each secretariat is responsible for maintaining and enforcing compliance with this policy. Any inappropriate dress or appearance issues will be addressed with employee or volunteer by the Secretary or his staff designee. Repeated non-compliance could result in disciplinary action, including dismissal.

I _____, acknowledge that I have received a copy of the Personnel Policies Manual for the Diocese of Lake Charles as of July 1, 2018 (Revised date July 1, 2018).

I understand that these are policies which are intended to guide my employment relationship with the Diocese of Lake Charles. I also understand that these policies are not intended to, nor do they constitute a contract, and that the Diocese may deviate from, revise or discontinue these policies, or institute new policies at its discretion.

Furthermore, either the Diocese or I can decide to discontinue our employer-employee relationship at any time, and these policies are not intended to alter the at-will nature of my employment.

I further understand it is my responsibility to review and be knowledgeable of the rules, policies and other information in this manual and if clarification is needed, I can consult with the Business Manager.

Employee (Signature)

Date