To: Employees with New Jersey State Health Benefits and Pension

From: Human Resources

Re: Change of Name

All employees with health benefits or pension that require a change of name must complete the attached forms:

   New Jersey Affidavit- Change of Name       (Please note this form needs to be notarized)
   State of New Jersey Health Benefits Application

Please submit the completed forms with your new Social Security card to Human Resources Bunce Hall for processing.

Thank You
STATE OF NEW JERSEY
Department of the Treasury — Division of Pensions and Benefits
PO Box 295, Trenton, New Jersey 08625-0295

AFFIDAVIT — CHANGE OF NAME

Retirement System:  □ Public Employees' Retirement System  □ Teachers' Pension and Annuity Fund

□ State Police Retirement System  □ Police and Firemen's Retirement System  □ Other

1. Previous Name ____________________________________________________________

2. Membership Number _____________________________________________________

3. Social Security Number __________________________________________________

4. Change the records of the Division of Pensions and Benefits

to reflect my name as ______________________________________________________

5. Reason for Name Change ________________________________________________

6. My signature as previously written was _____________________________________

7. My signature as it will be in the future is ____________________________________

8. My present address is ____________________________________________________

                     (Street)

                     (City, State, Zip Code)

                     (Area Code)  (Phone Number)

                     (Your Signature)

State of _________________________________________________________________

County of ______________________________________________________________

Sworn and subscribed before me this __________________ day of __________________, __________________

Signature of Notary or Commissioner of Deeds __________________________________

My Commission expires __________________ / __________________ / ________________

Official Title _____________________________________________________________
1. EMPLOYEE INFORMATION — Employee Name (last, first)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Birth Date</th>
<th>Social Security Number</th>
<th>Marital Status*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Telephone Number  
Personal E-mail Address

Street Address  
City  
State  
Zip

2. EMPLOYMENT STATUS

- Full Time
- Part Time
- Intermittent
- National Guard
- ACA (monthly only)

3. REASON FOR APPLICATION (check one)

- New Enrollment
- Transfer
- Open Enrollment
- Loss of Coverage
- Adding Dependents
- Deleting Dependents
- Waiver of Coverage
- Other

Reason:__________________________

Date of Event

4. TYPE and LEVEL OF COVERAGE

- Level
- Health
- Rx

- Single
- Parent/Child(ren)
- Member/Spouse/Civil Union
- Member/Domestic Partner
- Family

5. HEALTH PLAN

- HORIZON
  - OMNIA Health Plan
  - NJ DIRECT2030
  - NJ DIRECT15
  - NJ DIRECT1525
  - Horizon HMO

- AETNA
  - Aetna Liberty Plan
  - Aetna Freedom2030
  - Aetna Freedom15
  - Aetna Freedom1525
  - Aetna HMO

6. Dependent Information: List all eligible dependents and attach required proof of dependency documents.*

<table>
<thead>
<tr>
<th>Eligible Dependents Last Name, First Name</th>
<th>Social Security No.</th>
<th>Circle Relationship</th>
<th>Birth Date mmm/dd/yyyy</th>
<th>Gender</th>
</tr>
</thead>
</table>
| Spouse/Civil Union  
Domestic Partner |
Child (Natural, Adopted, Foster, Step, Legal Ward)  
Child (Natural, Adopted, Foster, Step, Legal Ward)  
Child (Natural, Adopted, Foster, Step, Legal Ward) |

* See Instructions page for detailed information

EMPLOYEE CERTIFICATION — I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous participation by medical providers, either doctors or facilities, in the plans. If either my physician or medical center terminates participation in my selected plan, I must select another doctor or medical center participating in that plan to receive the ‘in-network’ benefit. I authorize any hospital, physician, or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require. Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A.17:33A-8c.

7. Employee Signature:__________________________  Date:__________________________
INSTRUCTIONS FOR THE SHBP STATE ACTIVE EMPLOYEE GROUP
HEALTH BENEFITS ENROLLMENT and/or CHANGE FORM

SECTION 1 – EMPLOYEE INFORMATION – Complete entire section. Indicate Marital Status as follows: S (Single), M (Married), C (Civil Union), DP (Domestic Partner), D (Divorced), W (Widowed)

SECTION 2 – EMPLOYMENT STATUS – Check one block only

SECTION 3 – REASON FOR APPLICATION – Check one block only
- New Enrollment – New hire or HIPAA event
- Transfer – Active health benefits coverage transferring from another SHBP/SEBP location
- Open Enrollment – Annually in October
- Adding Dependents – Must be done within 60 days of event (i.e. birth, marriage, adoption – indicate reason and date)
- Deleting Dependents – Removal of covered dependents (indicate reason and date)
- Loss of Coverage – Enrolling because of loss of other coverage (application and HIPAA certificate submitted within 60 days of the loss of other coverage)
- Waiver of Coverage – Waive (decline) coverage
- Other (indicate reason and date)
- Reason – indicate reason
- Date of Event – indicate date

To waive (decline) coverage: If you wish to waive Health and/or Prescription Drug coverage under the provisions of N.J.S.A. 52:14-17.31a, check appropriate block. NOTE: Both Health AND Prescription Drug coverage MUST be waived to avoid paying a contribution. If you are waiving coverage for yourself or any or all of your eligible dependents because of other group health coverage, you may enroll in the future. You must provide proof of the loss of other coverage and submit it with your application within 60 days of the loss of other coverage. Otherwise you will be required to wait until the annual Open Enrollment.

SECTION 4 – TYPE AND LEVEL OF COVERAGE – Indicate by checking the appropriate block to enroll in Health and/or Rx (Prescription Drug)
- Single – coverage for you only
- Parent/Child(ren) – coverage for you and any eligible child(ren) under age 26
- Member/Spouse/Civil Union – coverage for you and your eligible spouse or your Civil Union Partner
- Member/Domestic Partner – coverage for you and your eligible Domestic Partner
- Family – coverage for you, your eligible Spouse/Civil Union Partner/Domestic Partner, and child(ren) under age 26

SECTION 5 – HEALTH PLAN – Select only one plan. The Health Benefits Summary Program Description provides you with all available options at www.state.nj.us/treasury/pensions/handbooks.shtml Employees who wish to enroll in a High Deductible Health Plan (HDHP) must use the appropriate application found on our website www.nj.gov/treasury/pensions

SECTION 6 – DEPENDENT INFORMATION – List all eligible dependents and attach dependent documentation proof (see attached). If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. Ensure your dependents match your level of coverage (Section 4). Your child(ren) may be covered until the end of the calendar year they turn 26. ANY DEPENDENTS NOT LISTED WILL NOT BE COVERED.

NOTE: Use Section 3 to delete dependents.

SECTION 7 – EMPLOYEE SIGNATURE – Read, sign, date, and attach required dependent documentation. Return the application to your employer’s Human Resources office for certification.

MISREPRESENTATION: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties pursuant to N.J.S.A. 17:33A-6c.

EMPLOYER CERTIFICATION – Must be completed by the Certifying Officer. The Certifying Officer’s signature confirms that:
- The employee is eligible
- The application is legible and completed in its entirety
- The employee’s selected plans and coverage levels are appropriate
- The dependent documentation provided is complete and correct
- The Employer Certification section is completed in its entirety and
- The information presented is true to the best of their knowledge

HA-0691-0617
The State Health Benefits Program (SHBP) and School Employees' Health Benefits Program (SEHBP) are required to ensure that only employees, retirees, and eligible dependents are receiving health care coverage under the Programs. The DPB (Division of Pensions & Benefits) must guarantee consistent application of eligibility requirements within the plans. Employees or retirees who enroll dependents for coverage (spouses, civil union partners, domestic partners, children, disabled and/or age by age children continuing coverage) MUST submit the following documentation in addition to the appropriate health benefits enrollment or change of status application. If proper documentation has already been provided and approved, do not resubmit. If appropriate dependent documentation proof is not provided, dependents may not be enrolled. **ANY DEPENDENTS NOT LISTED ON THE APPLICATION WILL NOT BE COVERED.**

<table>
<thead>
<tr>
<th>DEPENDENTS</th>
<th>ELIGIBILITY DEFINITION</th>
<th>DOCUMENTATION REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPOUSE</td>
<td>A person to whom you are legally married.</td>
<td>A copy of the marriage certificate and a copy of the front page of the employee/retiree's federal tax return* (Form 1040) from last year that includes the spouse. If filing separately, submit a copy of both spouses' tax returns that list the same address. If marriage occurred in the current calendar year, a copy of the tax return is not required. Or, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both partners and is received at the same address.</td>
</tr>
<tr>
<td>CIVIL UNION PARTNER</td>
<td>A person of the same sex with whom you have entered into a civil union.</td>
<td>A copy of the New Jersey civil union certificate or a valid certification from another jurisdiction that recognizes same-sex civil unions and a copy of the front page of the employee/retiree's NJ tax return* from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Civil Union occurred in the current calendar year a copy of the tax return is not required. Or, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 day of the application) that includes the names of both partners and is received at the same address.</td>
</tr>
<tr>
<td>DOMESTIC PARTNER</td>
<td>A person of the same sex with whom you have entered into a domestic partnership. Under Chapter 246, P.L. 2003, the Domestic Partnership Act, health benefits coverage is available to domestic partners of State employees, State retirees, or employees or retirees of a SHBP or SEHBP participating local public entity that has adopted a resolution to provide Chapter 246 health benefits.</td>
<td>A copy of the New Jersey certificate of domestic partnership dated prior to February 19, 2007 or a valid certification from another State or foreign jurisdiction that recognizes same-sex domestic partners and a copy of the front page of the employee/retiree's NJ tax return* from last year that includes the partner. If filing separately, submit a copy of both partners' NJ tax returns that list the same address. If Domestic Partnership occurred in the current calendar year, a copy of the tax return is not required. Or, if tax return is not available, provide a copy of a bank statement or bill (dated within 90 days of the application) that includes the names of both partners and is received at the same address.</td>
</tr>
</tbody>
</table>
| CHILDREN         | A subscriber's child until age 25, regardless of the child's marital, student, or financial dependency status – even if the young adult no longer lives with his or her parents. This includes a stepchild, foster child, legally adopted child, or any child in a guardian-ward relationship upon submitting required supporting documentation. | Natural or Adopted Child – A copy of the child's birth certificate showing the name of the employee/retiree as a parent.
Step Child – A copy of the child's birth certificate showing the name of the employee/retiree's spouse or partner as a parent and a copy of the marriage/partnership certificate showing the names of the employee/retiree and spouse/partner.
Legal Guardian, Grandchild, or Foster Child – Copies of final court orders with the presiding judge's signature and seal. Documents must attest to the legal guardianship by the employee. |
| DEPENDENT CHILDREN WITH DISABILITIES | If a covered child is not capable of self-support when he or she reaches age 25 due to mental illness or incapacity, or a physical disability, the child may be eligible for a continuation of coverage. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP/SEHBP, (2) the child continues to be disabled, (3) the child is unmarried or does not enter into a civil union or domestic partnership, and (4) the child remains substantially dependent on you for support and maintenance. You may be contacted periodically to verify that the child remains eligible for coverage. | Documentation for the appropriate "child" type (as noted above) and a copy of the front page of the employee/retiree's Federal tax return* (Form 1040) from last year that includes the child. If Social Security disability has been awarded, or is currently pending, please include this information with the documentation that is submitted. Please note that this information is only verifying the child's eligibility as a dependent. The disability status of the child is determined through a separate process. |
| CONTINUED COVERAGE FOR COVERED CHILDREN | Certain children over age 25 may be eligible for continued coverage until age 31 under the provisions of Chapter 575, P.L. 2005. This includes a child by blood or law who: (1) is under the age of 31; (2) is unmarried or not a partner in a civil union or domestic partnership; (3) has no dependent(s) of his or her own; (4) is a resident of New Jersey or is a student at an accredited public or private institution of higher education, with at least 15 credit hours; and (5) is not provided coverage as a subscriber, insured, enrollee, or covered person under a group or individual health benefits plan, church plan, or entitled to benefits under Medicare. | Documentation for the appropriate "child" type (as noted above), and a copy of the front page of the child's federal tax return* (Form 1040) from last year, and if the child resides outside of the State of New Jersey, documentation of full time student status must be submitted. |

*You may black out all financial information and all but the last four digits of any Social Security numbers on tax returns. To obtain copies of the documents listed above, contact the office of the town clerk in the city of the birth, marriage, etc., or visit these websites: www.vitalrec.com or www.studentclearinghouse.org Residents of New Jersey can obtain records from the State Bureau of Vital Statistics and Registration website: www.nj.gov/health/vital/index.shtml
Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

* Is age 65 or older,
* Is blind, or
* Will claim adjustments to income, tax credits, or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the Personal Allowances Worksheet below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple job situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances for regular wages. Withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individual. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. For credits for child or dependent care expenses and the child tax credit, see the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES. Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 555 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding will usually be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 555 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1992. Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After you complete Form W-4, take effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $160,000 (Married). Future developments. Information about any future developments affecting Form W-4 such as legislation enacted after we release it will be posted at www.irs.gov/w4.

Personal Allowances Worksheet (keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent.

B Enter "1" if:

* You're single and have only one job; or
* You're married, have only one job, and your spouse doesn't work; or
* You wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

C Enter "1" for your spouse. But, you may choose to enter "0-0" if you are married and have either a working spouse or more than one job. (Entering "0-0" may help you avoid having too little tax withheld.)

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

E Enter "1" if you will file as head of household on your tax return (see conditions under Head of household above).

F Enter "1" if you have at least $2,000 of child or dependent care expenses for which you plan to claim a credit.

(Note: Do not include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

* If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then less "1" if you have two or more eligible children or less "2" if you have five or more eligible children.
* If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child.

H Add lines A through G and enter total here. (Note: This may be different from the number of exemptions you claim on your tax return.)

For accuracy, complete all worksheets that apply.

If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.

If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.

If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

Employee's Withholding Allowance Certificate

Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

1 Your first name and middle initial
2 Your social security number
3 Single Married Married, but withhold at higher Single rate. (If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.)
4 If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.
5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)
6 Additional amount, if any, you want withheld from each paycheck
7 I claim exemption from withholding for 2017, and certify that I meet both of the following conditions for exemption:

* Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
* This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

If you meet both conditions, write "Exempt" here.

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

Employee's signature (This form is not valid unless you sign it.)
8 Employer's name and address (Employer: Complete lines 8 and 10 if signing to the IRS)
9 Office code (optional)
10 Employer identification number (EIN)

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 1022OQ Form W-4 (2017)
Deductions and Adjustments Worksheet

Note: Use this worksheet only if you plan to itemize deductions or claim certain credits or adjustments to income.

1. Enter an estimate of your 2017 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 10% of your income, and miscellaneous deductions. For 2017, you may have to reduce your itemized deductions if your income is over $313,800 and you're married filing jointly or you're a qualifying widow(er); $261,500 if you're single, not head of household and not a qualifying widow(er); or $156,900 if you're married filing separately. See Pub. 505 for details.
   
   Enter: $12,700 if married filing jointly or qualifying widow(er)  
   $9,350 if head of household  
   $6,550 if single or married filing separately
   
   1 $  

2. Subtract line 2 from line 1. If zero or less, enter "-0-".
   
   Enter: $3 $  

3. Enter an estimate of your 2017 adjustments to income and any additional standard deduction (see Pub. 505).

4. Add lines 3 and 4 and enter the total. (Include any amount for credits from the Converting Credits to Withholding Allowances for 2017 Form W-4 worksheet in Pub. 505.)

5. Enter an estimate of your 2017 nonwage income (such as dividends or interest).

6. Subtract line 6 from line 5. If zero or less, enter "-0-".

7. Divide the amount on line 7 by $4,050 and enter the result here. Divide any fraction.

8. Enter the number from the Personal Allowances Worksheet, line H, page 1.

9. Add lines 8 and 9 and enter the total here. If you plan to use the Two-Earners/Multiple Jobs Worksheet, also enter this total on line 1 below. Otherwise, stop here and enter this total on Form W-4, line 5, page 1.

Two-Earners/Multiple Jobs Worksheet (See Two earners or multiple jobs on page 1.)

Note: Use this worksheet only if the instructions under line H on page 1 direct you here.

1. Enter the number from line H, page 1 (or from line 10 above if you used the Deductions and Adjustments Worksheet).

2. Find the number in Table 1 below that applies to the LOWEST paying job and enter it here. However, if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3".

3. If line 1 is more than or equal to line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-" and on Form W-4, line 5, page 1. Do not use the rest of this worksheet.

4. Enter the number from line 2 of this worksheet.

5. Enter the number from line 1 of this worksheet.

6. Subtract line 5 from line 4.

7. Find the amount in Table 2 below that applies to the HIGHEST paying job and enter it here.

8. Multiply line 7 by line 6 and enter the result here. This is the additional annual withholding needed.

9. Divide line 8 by the number of pay periods remaining in 2017. For example, divide by 26 if you are paid every two weeks and you complete this form on a date in January when there are 25 pay periods remaining in 2017. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck.

Table 1

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from LOWEST paying job are:</td>
<td>Enter on line 2 above</td>
</tr>
<tr>
<td>$0 - $7,000</td>
<td>0</td>
</tr>
<tr>
<td>7,001 - 14,000</td>
<td>1</td>
</tr>
<tr>
<td>14,001 - 22,000</td>
<td>2</td>
</tr>
<tr>
<td>22,001 - 27,000</td>
<td>3</td>
</tr>
<tr>
<td>27,001 - 35,000</td>
<td>4</td>
</tr>
<tr>
<td>35,001 - 44,000</td>
<td>5</td>
</tr>
<tr>
<td>44,001 - 55,000</td>
<td>6</td>
</tr>
<tr>
<td>55,001 - 65,000</td>
<td>7</td>
</tr>
<tr>
<td>65,001 - 75,000</td>
<td>8</td>
</tr>
<tr>
<td>75,001 - 80,000</td>
<td>9</td>
</tr>
<tr>
<td>80,001 - 85,000</td>
<td>10</td>
</tr>
<tr>
<td>85,001 - 115,000</td>
<td>11</td>
</tr>
<tr>
<td>115,001 - 130,000</td>
<td>12</td>
</tr>
<tr>
<td>130,001 - 140,000</td>
<td>13</td>
</tr>
<tr>
<td>140,001 - 150,000</td>
<td>14</td>
</tr>
<tr>
<td>150,001 and over</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Married Filing Jointly</th>
<th>All Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>If wages from HIGHEST paying job are:</td>
<td>Enter on line 7 above</td>
</tr>
<tr>
<td>$0 - $75,000</td>
<td>$610</td>
</tr>
<tr>
<td>75,001 - 135,000</td>
<td>1,010</td>
</tr>
<tr>
<td>135,001 - 205,000</td>
<td>1,130</td>
</tr>
<tr>
<td>205,001 - 260,000</td>
<td>1,340</td>
</tr>
<tr>
<td>260,001 - 405,000</td>
<td>1,420</td>
</tr>
<tr>
<td>405,001 and over</td>
<td>1,600</td>
</tr>
</tbody>
</table>

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 6104 and 6169 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 who claims no withholding allowances, 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 non-tax 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.