Westarea Volunteer Fire Department

8716 E. Reeves Bridge Road
Linden, North Carolina 28356
Phone (910) 822-0901
FAX (910 822-0440
WestareaFD@nc.rr.com

Employment/Member Packet

Name: _____

This packet contains:

All	**General Information Sheet**
All	**Employment/Member Application**
All	**Autopsy Release Form** (*MUST BE NOTARIZED)*
All	**Beneficiary Form**
Employee	**Federal W-4 Tax Withholding Form**
Employee	**State NC-4 Tax Withholding Form**
Employee	**Form I-9, Employment Eligibility Verification**
Employee	**Direct Deposit Form**
All	**Drug Free Workplace Form**
All	**Request For Drug Test**
All	**Background Check Form**

Required Attachments:

- ☐ **Background Check**
- ☐ **Copy of Driver License**
- ☐ **Copy of Social Security Card**
- ☐ **Copy of State Certifications** *(If applicable)*
- ☐ **Copy of current CPR Card** *(If applicable)*

****NOTE** - Incomplete applications will not be processed.**

Administrative Use only **Do not write in this area**

Date Application Received	_____	Add to Workman's Compensation Roster	_____
Date of Chief's Interview	_____	Add to NCSFA Roster Online	_____
References Checked By	_____	Add to I AM RESPONDING Roster	_____
Completion Date of Drug Screen	_____	Add to FIRST DUE	_____
Date Appointed – 30 Day Trial	_____	Date of Full Membership	_____

Westarea Volunteer Fire Department
EMPLOYEE GENERAL INFORMATION

Name: _____

Home Address:

City | State | Zip Code
NC

Mailing Address: *(If different from home address)*

City | State | Zip Code
NC

Social Security Number:
- -

Sex:
Male ☐ Female ☐

Email address

Date of Birth: *MM/DD/YYYY*
/ /

Cell Phone:
( )

Home Phone:
( )

Work Phone | Ext.:
( )

EMERGENCY CONTACTS

Name:

Address:

City: | State | Zip Code

Phone Number:
( )

Alternate Phone Number:
( )

Name:

Address:

City: | State | Zip Code

Phone Number:
( )

Alternate Phone Number:
( )

Hire Date*: MM/DD/YYYY*
/ /

Member ☐ Employee ☐

Westarea Volunteer Fire Department, Inc.
8716 E. Reeves Bridge Road
Linden, NC 28356

Application for Employment/Membership

Type or print clearly in black ink. Complete all areas (* = membership only)

GENERAL INFORMATION

1. Name (Last, First, Middle)

2. Mailing Address

City | State | ZIP Code

N C

3. Social Security Number

4. Sex ☐ Male ☐ Female

5. Birth Date (Month, Day, Year)

6. Birthplace (City and State)

7. Home Phone (910)

8. Cell Phone ( )

9. Have you ever been a member or employee of Westarea?
☐Yes ☐No If yes, From To

AVAILABILITY

10 When can you start?

11* Will you be able to attend Thursday night training? ☐ Yes ☐ No

12* Members: Which station location is closest to your residence?
☐Ramsey St ☐Linden

12a Employment: Westarea currently operates 3 stations. Do you agree to work at any of these stations when assigned.

☐ Yes ☐ No _____

13* Are you normally available:	YES	NO
a. Daytime?		
b. Nights?		
c. Weekends?		
d. Holidays?		
14 Do you have your own dependable transportation?		

QUALIFICATIONS

15 Do you have the following or equivalent?	YES	NO
a. High School Diploma or GED		
b. NC Class "B" Driver License		
c. NC Firefighter II Certification		
d. NC Driver/Operator Certification		
e. NC Haz-Mat Operations Certification		
f. NC EMT Certification		
g. Previous Firefighter work experience		

MEDICAL

	YES	NO
16 Are there any special accommodations you will require to do the job applying for?		

Explain if YES

17 Do you agree to a complete physical and drug screening as a condition of employment/membership within 7 days of acceptance this application?

☐ Yes ☐ No _____
Signature

DO NOT WRITE IN THIS AREA

Date Application Received: _____
References checked by: _____
Background checked by: _____
Date of Chief's Interview: _____
Date of Medical Tests: _____
Results of Medical Tests: _____
Date Medical Results Received _____
Date appointed to probation: _____
Date of full membership: _____
Date membership ended: _____
Reason membership ended: _____

EDUCATION

18 Did you graduate from high school? If you have a GED high school equivalency, answer "YES".

YES ▶ If "YES", give month and year graduated or received GED Equivalency: ……

NO ▶ If "NO", give the highest grade completed: ……

19 Write the location (city and state) of the last high school you attended or where you obtained your GED.

20 Have you ever attended college or graduate school?

YES ▶ If "YES", go to 21

NO ▶ If "NO", go to 22

21 Name and location (city, state and Zip Code) of college or university.

	NAME AND LOCATION	Major Field of Study	Month and Year Attended From	Month and Year Attended To	Number of Credit Hours Completed Semester	Number of Credit Hours Completed Quarter	Type of Degree	Month and Year of Degree
1.								
2.								
3.								

WORK EXPERIENCE *If you have no work experience, write NONE in Box A below*

22. May we ask your present employer about your character, qualifications, and work record? A "NO" answer will not affect our review of your qualifications. If you answer "NO" and we need to contact your present employer before we can offer you a job, we will contact you first.

YES ☐ NO ☐

- Describe your current or most recent job in Block A and work backwards, describing each job you held during the past ten years.
- LIST all experience you have had with a fire department, whether that experience was full-time, part-time, or as a volunteer. You may also list other volunteer work that you feel is relevant to the job for which you are applying.
- If you need more space to describe a job or you need additional blocks to list all of your work experience, you may use sheets of paper the same size as this page and attach them to your application.

A Name and address of employer's organization

Dates employed (month, year) FROM: TO:

Average Hours per week

Number of employees you supervise

Exact title of your job

Your immediate supervisor NAME

Telephone No. ( )

Your reason for wanting to leave

Description of work: Describe your specific duties, responsibilities and accomplishments in this job.

B Name and address of employer's organization

Dates employed (month, year) FROM: TO:

Average Hours per week

Number of employees you supervise

Exact title of your job

Your immediate supervisor NAME

Telephone No. ( )

Your reason for wanting to leave

Description of work: Describe your specific duties, responsibilities and accomplishments in this job.

C Name and address of employer's organization\	Dates employed (month, year) FROM: TO:	Average Hours per week	Number of employees you supervise
	Exact title of your job		
Your immediate supervisor NAME / Telephone No. ( )	Your reason for wanting to leave		

Description of work: Describe your specific duties, responsibilities and accomplishments in this job.

REFERENCES

23 List three people who are not related to you, who know your qualifications and fitness for the kind of job for which you are applying. If applying as a volunteer of Westarea Fire Department skip to Section 24.

FULL NAME OF RREFERENCE	TELEPHONE NUMBERS	BUSINESS OR HOME ADDRESS (Number, Street, and City)	STATE	ZIP CODE

BACKGROUND INFORMATION

Note: It is important that you give complete and truthful answers to the questions in this section. If you answer "YES" to any of them, provide your explanation(s) below. Omit traffic offenses for which you paid a fine of $100.00 or less, any violation committed before your 16th birthday, and any conviction expunged under Federal or State law. However, if you fail to tell the truth or fail to list all relevant events or circumstances, this may be justification for not accepting your application or for dismissing you after you become a member. Each applicant must provide a Criminal Background Check for 5 years and Driver License Check for 3 years along with this application.

		YES	NO
24	Are you a citizen of the United States? (In most cases you must be a U.S. Citizen to be hired. You will be required to submit proof of identity and citizenship at the time you are hired.) ……		
25	During the last 10 years, were you fired from any job for any reason, did you quit after being told that you would be fired? **(Full time applicants only)** ……		
26	Have you ever been convicted of, or forfeited collateral for any misdemeanor of felony violation? ……		
27	Are you now under charges for any violation of law? ……		

28 If your answer to 25, 26, or 27 above is "YES", explain the circumstances in this space. For 25, give the employers name and address. For 26 and 27, give the city, state, county, and the violation involved as well as any penalties imposed. For additional space, attach sheets of paper as needed.

29 If you have a drivers license provide the following:

STATE: CLASS: NUMBER: RESTRICTIONS: EXPIRES:

SIGNATURE, CERTIFICATION, AND RELEASE OF INFORMATION

YOU MUST SIGN THIS APPLICATION. Read the following carefully before you sign.

- A false statement on any part of your application may be grounds for denying membership.
- I consent to the release of information about my ability and fitness for employment by employers, schools, law enforcement agencies and other individuals and organizations, to authorized employees of Westarea Volunteer Fire Department, Inc.
- I certify that, to the best of my knowledge and belief, all of my statements are true, correct, complete, and made in good faith.

30	SIGNATURE (Sign in dark ink)	31	DATE SIGNED (Month, Day, Year)

Westarea Volunteer Fire Department

8716 E. Reeves Bridge Road
Linden, North Carolina 28356
Phone (910) 822-0901
FAX (910 822-0440
WestareaFD@nc.rr.com

MEMORANDUM FOR CUMBERLAND COUNTY, NORTH CAROLINA

FROM: _____
Westarea Volunteer Fire Department Firefighter (Print)

RE: Authorization to Perform an Autopsy

The undersigned, being a fire fighter in the above County and State, and recognizing that the duties of a fire fighter are dangerous and may result in death, and realizing further that it may be difficult to prove that death was a result of injuries sustained in the line of duty in order to secure the benefits provided for the survivors:

Now, therefore, pursuant to G. S. 130-398, in the event I shall die under circumstances that could possibly be related to firefighting activities, it is directed that an autopsy be performed on my body and that the results be made available for any action in connection with the securing of benefits due my survivors under local, State or Federal Law.

This _____ day of _____ , 20 _____

_____
Signature

NORTH CAROLINA CUMBERLAND COUNTY

I, _____, A Notary Public in and for the said County and State, Hereby certify that _____personally appeared before me this day and acknowledged the due execution of the foregoing authorization.

Witness my hand and notaries seal, this the _____day of _____, 20_____.

_____
NOTARY PUBLIC
(SEAL) My Commission Expires: _____

183 Leader Heights Road
P.O. Box 2726
York, PA 17405
(800) 233-1957 or (717) 741-0911
www.vfis.com

BENEFICIARY DESIGNATION FORM

This form may be used for multiple Policies when designating the same beneficiary. Use a separate form when designating different beneficiaries for each Policy.

Indicate one of the following:

☐ New Insured ☐ Beneficiary Change ☐ Name Change: From: _____

Complete all of the following information:

Policyholder Name and Policy Number(s) *(Emergency Service Organization Name)*

☐ Group Term Life	**Policyholder**	WESTAREA VFD INC	**Policy #**	CVT301240R
☐ Accident & Sickness	**Policyholder**	CUMBERLAND COUNTY - WESTAREA	**Policy #**	VFP-4634-1262E-05
☐ _____	**Policyholder**		**Policy #**	
☐ _____	**Policyholder**		**Policy #**	

☐ **Other** _____

☐ **Other** _____

Last Name	**First Name**	**MI**

Date of Birth	**Date of Membership**	**Social Security Number**
		/ /

I hereby designate the following beneficiary(ies) to receive any death benefit proceeds payable under the policies checked above. If this form represents a change of beneficiary, the present beneficiary designation(s) are terminated and the following designation(s) made:

BENEFICIARY DESIGNATION – Primary Class	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)
BENEFICIARY DESIGNATION – Contingent Class	**Relationship to Insured**	**Date of Birth**	**Percent** (Must equal 100%)

MINOR OR ESTATE AS BENEFICIARY: If death occurs and a minor child (a person under the age of majority) or your estate is designated as beneficiary, it may be necessary to have a guardian or legal representative appointed before any death benefit can be paid. This could mean legal expenses for the beneficiary and possible delay in the payment of any death benefit. Please take this into consideration when designating your beneficiary.

Insured's Signature: _____ Date: _____

Sample wording for Beneficiary Designations

Class	**Relationship to Insured**	**Percent**
One Beneficiary of a class Jane Ann Jones	Spouse	100%
Two or more Beneficiaries of a class: Arthur Leo Jones Grace Hays Jones	Father Mother	50% 50%
Unnamed Children: Children of the Named Insured		Split Equally
Unequal distribution: Grace Hays Jones Mary Jones Ford William Roger Jones	Mother Sister Brother	50% 25% 25%
Insured's Estate	Executors or Administrators of the Insured's Estate	

This form should be retained by the Policyholder with a copy to the insured.

* Primary Beneficiary is the person(s) who will receive the insurance proceeds.

** Contingent Beneficiary is the person(s) who will receive the insurance proceeds if the primary beneficiary is not alive at your death.

North Carolina
Total Retirement Plans

Form 2FR
Designating Beneficiary(ies) for the Firefighters' and Rescue Squad Workers' Pension Fund

Department of State Treasurer, Retirement Systems Division
3200 Atlantic Avenue • Raleigh, NC 27604 •
web: www.myNCRetirement.com
phone: 919-814-4590 • fax: 919-855-5800

Complete all sections of this form and read the attached Guides. After completing and signing this form before a notary public, send it to the address above. This form is not valid until it has been properly completed, notarized, and received by our office **prior to your death**. Forms submitted with erasures, strike overs, or white-outs in Sections B through E may not be accepted.

Section A. Tell us about yourself.

☐ Check if there are any changes to your contact information.

First Name	M.I.	Last Name	Suffix	SSN (Last 4 digits)

Mailing Address	e-Mail Address	Member ID
	TBR	

City	State	ZIP	Telephone	Date of Birth

Section B. Select your beneficiary(ies) for Return of Undistributed Contributions. *See Guides for assistance.*

1

First Name*	M.I.	Last Name*	Date of Birth*

Address	City	State	ZIP

Relationship	Social Security Number*

E-Mail Address	Telephone

Select a Beneficiary Type *(Select one)*
☐ Principal
☐ Contingent

You may list one or multiple principal beneficiaries, but be aware of how yours choice will affect benefits payable in the event you are killed in the line of duty.

Effective July 1, 2018, if you are killed in the line of duty as determined by the North Carolina Industrial Comission, and you have one and only one principal beneficiary that is eligible and has not accepted a return of undistributed contributions, your living beneficiary may choose to receive a monthly lifetime benefit (known as the Survivorship Benefit), rather than a one-time payment (known as a return of Undistributed Contributions).

☐ If you are designating more beneficiaries, check the box at left and complete Page 2.

Read Guide A for more information about beneficiary(ies) elections and potential impacts on your benefits.

***REQUIRED FIELD**

Section C. Certify your selections.

I hereby authorize the Board of Trustees to make payment(s) to the beneficiary(ies) I have designated on this form. I acknowledge that the payments shall be a complete discharge of any claim and shall constitute a release of the Retirement System from any further obligation on my account. I understand that by completing and signing this form I acknowledge having read the attached Guides. I reserve the right to change the beneficiary(ies) designated on this form in accordance with the information provided. In addition, I understand that the Retirement System may not accept this form with any erasures, strike overs, or white-outs in Sections B through E. I certify by my signature that I have completed this form in its entirety.

Signature _____ Date_____

Section D. Have this form notarized. *Improperly notarized forms will not be accepted.*

State of _____ County of _____ My Commission Expires _____

I, _____, a notary public for said State and County, do hereby

certify that _____ personally appeared before me

this date and acknowledge the due execution of this form.

Witness my hand and official seal this the _____ day of _____ , 20_____

Signature of Notary _____

North Carolina
Total Retirement Plans

Form 2FR
Designating Beneficiary(ies) for the Firefighters' and Rescue Squad Workers' Pension Fund

Department of State Treasurer, Retirement Systems Division
3200 Atlantic Avenue • Raleigh, NC 27604
web: www.myNCRetirement.com
phone: 919-814-4590 • fax: 919-855-5800

This page is intended as a supplement to Page 1, and is optional. If you have more beneficiaries to designate, complete this page and submit with Page 1. Please note that forms submitted with erasures, strike overs, or white-outs in Sections B through E may not be accepted.

Section E. Select your additional beneficiary(ies). (Optional) ***See Guides for assistance. *REQUIRED FIELD***

Please select additional beneficiaries. You do not need to repeat any beneficiaries listed on Page 1.

2

First Name*	M.I.	Last Name*	Date of Birth*
Address	City	State	ZIP
Relationship	Social Security Number*		
E-Mail Address	Telephone		

Select a Beneficiary Type *(Select one)*
☐ Principal
☐ Contingent

3

First Name*	M.I.	Last Name*	Date of Birth*
Address	City	State	ZIP
Relationship	Social Security Number*		
E-Mail Address	Telephone		

Select a Beneficiary Type *(Select one)*
☐ Principal
☐ Contingent

4

First Name*	M.I.	Last Name*	Date of Birth*
Address	City	State	ZIP
Relationship	Social Security Number*		
E-Mail Address	Telephone		

Select a Beneficiary Type *(Select one)*
☐ Principal
☐ Contingent

5

First Name*	M.I.	Last Name*	Date of Birth*
Address	City	State	ZIP
Relationship	Social Security Number*		
E-Mail Address	Telephone		

Select a Beneficiary Type *(Select one)*
☐ Principal
☐ Contingent

6

First Name*	M.I.	Last Name*	Date of Birth*
Address	City	State	ZIP
Relationship	Social Security Number*		
E-Mail Address	Telephone		

Select a Beneficiary Type *(Select one)*
☐ Principal
☐ Contingent

***REQUIRED FIELD**

North Carolina
Total Retirement Plans

Department of State Treasurer, Retirement Systems Division
3200 Atlantic Avenue • Raleigh, NC 27604
web: www.myNCRetirement.com
phone: 919-814-4590 • fax: 919-855-5800

Form 2FR Guides
Designating Beneficiary(ies) for the Firefighters' and Rescue Squad Workers' Pension Fund

Guide A. What **are the benefits available by designating beneficiaries on Form 2FR?**

Return of (Undistributed) Contributions Benefit
Effective July 1, 2018, if any firefighter or rescue squad worker dies, except if the individual is killed in the line of duty, contributions made by you or on your behalf to the Pension Fund, plus any amount you paid to purchase retirement credit, will be distributed to the beneficiary(ies) you designate. Your beneficiary(ies) is entitled to these contributions whether or not you are in active service at the time.

Any beneficiary must meet the requirements in Guide B. You may change your beneficiary(ies) for this benefit at any time by completing a new Form 2FR.

You may list one or multiple principal beneficiaries, but be aware of how your choice may affect benefits payable in the event you are killed in the line of duty.

See your Retirement Benefits handbook located on our website at www.myNCRetirement.com for further information.

- If you choose to designate one principal beneficiary, you may designate one or multiple contingent beneficiary(ies).
- If you list multiple beneficiaries in any case, you may not assign percentages of the Return of Contributions to any individual; the benefit will be divided equally among multiple beneficiaries.

Survivorship Benefit
Effective July 1, 2018, if you are killed in the line of duty as determined by the North Carolina Industrial Commission, and you have one and ONLY one principal beneficiary that is eligible and has not accepted a return of undistributed contributions, your living beneficiary may choose to receive a monthly lifetime benefit (known as the Survivorship Benefit), rather than a one-time payment (known as a return of Undistributed Contributions). It is important to note that your estate for the Survivorship Benefit.

Guide B. What is the Guaranteed Refund?

The Guaranteed Refund feature provides that if you die before exhausting the total of your remaining undistributed contributions, any remaining portion will be paid in a lump sum payment to the beneficiary(ies) you designate.

If all of your undistributed contributions have been exhausted, your monthly benefit will continue, if applicable, but the Guaranteed Refund will not be payable.

Guide C. What are the different types of beneficiary(ies) I can select?

A **principal beneficiary** will be the first person(s) that you select to receive a benefit payment after your death. You may choose one or multiple principal beneficiaries. A **contingent beneficiary** will be the person(s) who will be paid only if all principal beneficiaries are deceased at the time of your death. You do not have to select any contingent beneficiaries, but if you do, you must select a principal beneficiary. Please see Guide A for information on multiple beneficiaries and potential impacts to your benefit.

You have the option to designate as a beneficiary:

- **One** living person.
- More than one living person to share the benefit equally.
- Your estate. Write ESTATE in the Last Name box under Section B.

Here are some guidelines you should follow when selecting beneficiaries:

- You must supply the name, Social Security number and date of birth for each beneficiary listed.
- Although there is no limit to the number of principal and contingent beneficiaries you may choose, you must choose at least one principal beneficiary before a contingent can be chosen.
- If you list multiple beneficiaries, you may not assign percentages of the benefit to any individual; the benefit will be divided equally among the beneficiaries.
- If you elect multiple beneficiaries, they will only be eligible for the Undistributed Contributions and the Survivorship Benefit will not be an option.
- If you elect you estate a principal beneficiary, your estate will only be eligible for the Undistributed Contributions and the Survivorship Benefit will not be an option.
- Your beneficiary(ies) cannot be an unborn child, a pet, a church, or institution.
- You don't need permission from the beneficiary(ies) to make or change the designation; however, if a court order directs you to designate someone as a beneficiary, you must comply with the order.
- You don't have to make your beneficiary(ies) aware of this designation.
- You don't have to name relatives as beneficiary(ies).

Guide D. How is this benefit paid to my beneficiary(ies)?

After your death is reported and a certified copy of the death certificate is received, the Retirement Systems Division will determine what benefits are payable. Any benefit will be paid to your principal beneficiary(ies), but if your principal beneficiaries are deceased at the time of your death, the benefit will be paid to any contingent beneficiary(ies). If you chose multiple co-beneficiaries and one is deceased at the time of your death, the benefit will be paid to the surviving co-beneficiary(ies).

If a beneficiary is a minor, payment will be made to the qualified guardian of the minor, the Clerk of Courts in the county where the minor lives, or the minor after he/she reaches the age of majority. (Generally, the age of majority in North Carolina is 18.)

If you named your estate as your beneficiary, or if no named principal or contingent beneficiary is alive at your death, payment will be made to your legal representative (usually your estate).

The availability and amount of all benefits that the retiree might be eligible to receive is governed by Retirement System law. The information provided in this guide cannot alter, modify, or otherwise change the controlling Retirement System law or other governing documents in any way, nor can any right accrue to the retiree or beneficiary by reason of any information provided or omission of information provided herein. In the event of a conflict between this information and Retirement System law, Retirement System law governs.

Westarea Volunteer Fire Department
Drug-Free Workplace
Policy

It is the policy of Westarea Volunteer Fire Department to provide a drug-free workplace.

The Westarea Volunteer Fire Department will not tolerate the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance on department premises. These activities are absolutely prohibited and will result in disciplinary action up to and including termination from the fire department.

All Westarea members (paid and volunteer) must, as a condition of membership an employment, adhere to this policy. Any member convicted under a criminal drug statue for violations occurring on or off department premises or while conducting department business must report the conviction to his/her station chief or to the Chief of Westarea, within five (5) days after the conviction.

The department reserves the right to take appropriate and lawful actions to enforce this Drug-free Workplace Policy, to include drug testing and inspection of any work area, department property or suspected areas of concealment.

The department recognizes drug dependency as an illness, and abuse as a potential health, safety and security problem. Personnel needing help in dealing with such problems are encouraged to use the department's insurance plan, as appropriate.

I have read the Drug-free Workplace Policy and accept it as a condition of membership/employment.

Signature _____ Date _____

Print Name _____

Westarea Volunteer Fire Department

8716 E. Reeves Bridge Road
Linden, North Carolina 28356
Phone (910) 822-0901
FAX (910 822-0440
WestareaFD@nc.rr.com

Direct Deposit Agreement Form

Authorization Agreement

I hereby authorize Westarea Volunteer Fire Dept., Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Westarea Volunteer Fire Dept., Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Westarea Volunteer Fire Dept., Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Westarea Volunteer Fire Dept., Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: _____

Routing Number: _____

Account Number: _____ Checking ☐ Savings ☐

Signature

Authorized (Primary): Print Name _____ **Date:** _____

Authorized (Primary): Signature _____ **Date:** _____

Authorized (Joint): Print Name _____ **Date:** _____

Authorized (Joint): Signature _____ **Date:** _____

Please attach a voided check or deposit slip and return this form to the Payroll Department.

Form **W-4**

Department of the Treasury
Internal Revenue Service

Employee's Withholding Certificate

▶ **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.**

OMB No. 1545-0074

2020

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

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 online estimator, 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 2020 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 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)
Westarea Volunteer Fire Dept. **8716 E. Reeves Bridge Rd.** **Linden, NC 28356**		**56-0991340**

NCDOR
Web
11-19

NC-4
Employee's Withholding Allowance Certificate

PURPOSE - Complete **Form NC-4** so that your employer can withhold the correct amount of State income tax from your pay. **If you do not provide an NC-4 to your employer, your employer is required to withhold based on the filing status, "Single" with zero allowances.**

FORM NC-4 EZ - You may use Form NC4-EZ if you plan to claim either the N.C. Standard Deduction or the N.C. Child Deduction Amount (but no other N.C. deductions), and you do not plan to claim any N.C. tax credits.

FORM NC-4 NRA - If you are a nonresident alien you must use Form NC-4 NRA. In general, a nonresident alien is an alien (not a U.S. citizen) who has not passed the green card test or the substantial presence test. *(See Publication 519, U.S. Tax Guide for Aliens, for more information on the green card test and the substantial presence test.)*

FORM NC-4 BASIC INSTRUCTIONS - Complete the NC-4 **Allowance Worksheet**. The worksheet will help you determine your withholding allowances based on federal and State adjustments to gross income including the N.C. Child Deduction Amount, N.C. itemized deductions, and N.C. tax credits. However, you may claim fewer allowances than you are entitled to if you wish to increase the tax withheld during the tax year. If your withholding allowances decrease, you must file a new NC-4 with your employer within 10 days after the change occurs. Exception: When an individual ceases to be "Head of Household" after maintaining the household for the major portion of the year, a new NC-4 is not required until the next year.

TWO OR MORE JOBS - If you have more than one job, determine the total number of allowances you are entitled to claim on all jobs using one Form NC-4 Allowance Worksheet. Your withholding will usually be most accurate when all allowances are claimed on the NC-4 filed for the higher paying job and zero allowances are claimed for the other. You should also refer to the "Multiple Jobs Table" to determine the additional amount to be withheld on Line 2 of Form NC-4 *(See page 4).*

NONWAGE INCOME - If you have a large amount of nonwage income, such as interest or dividends, you should consider making estimated tax payments using Form NC-40 to avoid underpayment of estimated tax interest. Form NC-40 is available on the Department's website at www.ncdor.gov.

HEAD OF HOUSEHOLD - Generally you may 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 individuals.

SURVIVING SPOUSE - You may claim "Surviving Spouse" filing status only if your spouse died in either of the two preceding tax years and you meet the following requirements:

1. Your home is maintained as the main household of a child or stepchild for whom you can claim a federal exemption; and
2. You were entitled to file a joint return with your spouse in the year of your spouse's death.

MARRIED TAXPAYERS - For married taxpayers, both spouses must agree as to whether they will complete the NC-4 Allowance Worksheet based on the filing status, "Married Filing Jointly" or "Married Filing Separately."

- Married taxpayers who complete the worksheet based on the filing status, "Married Filing Jointly" should consider the sum of both spouses' income, federal and State adjustments to income, and State tax credits to determine the number of allowances.
- Married taxpayers who complete the worksheet based on the filing status, "Married Filing Separately" should consider only his or her portion of income, federal and State adjustments to income, and State tax credits to determine the number of allowances.

All NC-4 forms are subject to review by the North Carolina Department of Revenue. Your employer may be required to send this form to the North Carolina Department of Revenue.

CAUTION: If you furnish an employer with an Employee's Withholding Allowance Certificate that contains information which has no reasonable basis and results in a lesser amount of tax being withheld than would have been withheld had you furnished reasonable information, you are subject to a penalty of 50% of the amount not properly withheld.

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

NCDOR
Web
10-17

NC-4
Employee's Withholding Allowance Certificate

1. **Total number of allowances you are claiming**
   (Enter zero (0), or the number of allowances from Page 2, Line 17 of the NC-4 Allowance Worksheet) ____
2. **Additional amount, if any, withheld from each pay period** *(Enter whole dollars)* ____.00

Social Security Number ___ ___ ____

Filing Status
○ Single or Married Filing Separately ○ Head of Household ○ Married Filing Jointly or Surviving Spouse

First Name *(USE CAPITAL LETTERS FOR YOUR NAME AND ADDRESS)* | M.I. | Last Name

Address | County *(Enter first five letters)*

City | State | Zip Code *(5 Digit)* | Country *(If not U.S.)*

Employee's Signature _____ Date _____

I certify, under penalties provided by law, that I am entitled to the number of withholding allowances claimed on Line 1 above.

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►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.

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):

☒ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): N/A

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): N/A
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

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.

1. Alien Registration Number/USCIS Number: N/A

OR

2. Form I-94 Admission Number: N/A

OR

3. Foreign Passport Number: N/A

Country of Issuance: N/A

QR Code - Section 1
Do Not Write In This Space

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

☒ ☐

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

STOP

Employment Eligibility Verification

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

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

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

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

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

Last Name (Family Name)	First Name (Given Name)	Middle Initial (if any)	Other Last Names Used (if any)

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

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

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

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

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

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

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

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

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

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

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

Additional Information

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

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

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

Last Name, First Name and Title of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)
Vermette-Chapman, Brandy Office administrator	Brandy Vermette-Chapman	

Employer's Business or Organization Name	Employer's Business or Organization Address, City or Town, State, ZIP Code
Westarea Volunteer Fire Dept.	**8716 E. Reeves Bridge Rd, Linden, NC 28356**

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