Voluntary Self-Identification of Disability

OMB Control Number 1250-0005
Expires 05/31/2023

First Name: _____ Last Name _____ Date: _____

Employee ID: _____
(if applicable)

Why are you being asked to complete this form?

We are a federal contractor or subcontractor required by law to provide equal employment opportunity to qualified people with disabilities. We are also required to measure our progress toward having at least 7% of our workforce be individuals with disabilities. To do this, we must ask applicants and employees if they have a disability or have ever had a disability. Because a person may become disabled at any time, we ask all of our employees to update their information at least every five years.

Identifying yourself as an individual with a disability is voluntary, and we hope that you will choose to do so. Your answer will be maintained confidentially and not be seen by selecting officials or anyone else involved in making personnel decisions. Completing the form will not negatively impact you in any way, regardless of whether you have self-identified in the past. For more information about this form or the equal employment obligations of federal contractors under Section 503 of the Rehabilitation Act, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition. *Disabilities include, but are not limited to:*

- Autism
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, or HIV/AIDS
- Blind or low vision
- Cancer
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or hard of hearing
- Depression or anxiety
- Diabetes
- Epilepsy
- Gastrointestinal disorders, for example, Crohn's Disease, or irritable bowel syndrome
- Intellectual disability
- Missing limbs or partially missing limbs
- Nervous system condition for example, migraine headaches, Parkinson's disease, or Multiple sclerosis (MS)
- Psychiatric condition, for example, bipolar disorder, schizophrenia, PTSD, or major depression

Please check one of the boxes below:

☐ Yes, I Have A Disability, Or Have A History/Record Of Having A Disability
☐ No, I Don't Have A Disability, Or A History/Record Of Having A Disability
☐ I Don't Wish To Answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

To request an accommodation, please contact Human Resources at RFhr@odu.edu or call any member of the HR team.

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

POST-EMPLOYMENT SELF-IDENTIFICATION

EMPLOYEE NAME: _____ **UIN**: _____

POSITION:_____**DEPARTMENT**:_____

Our Company is a federal contractor subject to various federal laws, regulations, and Executive Orders. As a federal contractor we are committed to affirmative action: to afford equal opportunity for employment and advancement in employment to qualified individuals regardless of their race, color, religion, sex, national origin, age, disability, veteran status, political affiliation, sexual orientation, genetic information, gender identity or any other basis prohibited by law. Information submitted will be kept confidential as required under applicable federal and/or state laws. Should you decide not to self-identify at this time, you may do so at any time in the future.

Gender - Check one: ☐ I do not want to identify ☐ Male ☐ Female

Race/Ethnicity - Check one:

☐ I do not want to identify.
☐ Hispanic or Latino
☐ White
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ Asian
☐ American Indian/Alaskan Native
☐ Two or more Races

Veteran Status - Check all that apply (*see reverse side for Veteran Status Definitions*):

☐ I do not want to identify/Not Applicable
☐ Not a veteran
☐ Active Duty Wartime or Campaign Badge Vet
☐ Active Reserve
☐ Disabled Veteran
☐ Inactive Reserve
☐ Armed Forces Service Medal Veteran
☐ Other Protected Veteran
☐ Recently Separated Veteran (within 1 year)
Discharge Date_ /_ /_
☐ Retired Veteran

Military Spouse - Check one:

☐ I do not want to identify/Not Applicable
☐ The wife or husband of an active or inactive duty military member of the Armed Forces, including a member of the U.S. Coast Guard.

Disability Information ï Consider Essential Job Function Limitations

What is the nature of your impairment? (Check all that apply.)

☐ I do not want to identify
☐ Not applicable
☐ Learning Disability
☐ Attention Deficit/Hyperactivity Disorder
☐ Psychological Impairment
☐ Visual Impairment
☐ Hearing Impairment
☐ Mobility Impairment
☐ Chronic Health Disorder
☐ Other_____

Briefly describe the ways in which your impairment may affect your ability to perform the duties of your position, and indicate any accommodations you are requesting.

Employee Signature:_____ Date:_____

Veteran Status Definitions:

(☐) Disabled Veteran

Either (1) a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administrated by the Secretary of Veterans Affairs, or (2) a person who was discharged or released from active duty because of a service-connected disability.

(☐) Recently Separated Veteran

Any veteran during the three year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval or air service.

Discharge Date (mm/dd/yyyy) : _____/_____/_____

(☐) Armed Forces Service Medal Veteran

Any veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces Service Medal was awarded pursuant to Executive Order 12985. (For the current list of military operations for which an Armed Forces Service Medal was awarded, visit http://www.opm.gov/staffingportal/vgmedal2.asp - Appendix A.

(☐) Active Duty Wartime or Campaign Badge Veteran

A veteran who served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense. (For the current list of campaigns and expeditions for which a campaign badge was authorized, visit http://www.opm.gov/staffingportal/vgmedal2.asp - Appendix A.

WRITTEN AFFIRMATIVE ACTION COMPLIANCE PROGRAM

The Contractor certifies that if it has 50 or more employees and if it anticipates sales to us in connection with government contracts of $50.000 or more, it will develop a written affirmative action compliance program for each of its establishments consistent with the rules and regulations published by the Department of Labor in 41 Code of Federal Regulations (hereinafter referred to as "C.F.R.") 60-2.

EE0-1 REPORT

The Contractor certifies that if it has 50 or more employees and if it anticipates sales to us in connection with Government contracts of $50,000 or more, it will file Standard Form 100 entitled: "Equal Employment Opportunity Employer Information Report EEO-1" as required by 41 C.F.R. Section 60-1.7.

EMPLOYMENT OF THE DISABLED

Pursuant to Section 503 of the Rehabilitation Act of 1973, and under 41 C.F.R. 60-741, the affirmative action clause set forth in section 741.4 of the regulations is considered to be included in every federal contractor subcontract exceeding $10,000.

Therefore, unless exempt, the Contractor certifies that it will take affirmative action to employ and advance in employment any qualified disabled individual, defined as "Any individual who has a physical or mental disability which for such individual constitutes or results in a substantial disability to employment."

The Equal Opportunity Clause may be put into subcontracts by reference, but only by citing the Equal Opportunity Clause in the regulations and including the following sentences in bold text**: This contractor and subcontractor shall abide by the requirements of 41 CFR 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability, and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities**.

The Contractor further certifies that it will obtain identical certifications from proposed subcontractors prior to the award of subcontracts exceeding $2,500 covering the procurement of personal property and non-personal services (including construction).

EMPLOYMENT OF PROTECTED VETERANS

41 C.F.R. 60-300 contains a clause required in every Federal invitation to bid or contract for $100,000 or more for the procurement of personal property and non-personal services (including construction), and every subcontract entered into in carrying out such contract, The clause which is included herein by reference (and which should be referred to in its entirety), requires among other things, that all suitable employment openings of the Contractor which exist at the time of the execution of the contract and those which occur during the performance of the contract, including those not generated by the contract and those occurring at an establishment of the Contractor other than the one wherein the contract is being performed but excluding those of independently operated corporate affiliates, shall be offered for listing at an appropriate local office of the State employment service system wherein the opening occurs and to provide such reports to such local office regarding employment openings and hires as may be required. The Contractor agrees to and certifies that it is in compliance with the above provision and that it will place it in any subcontract of $100,000 or more directly under this contract. Further, if required, the Contractor will annually file a VETS-4212 Report.

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):

☐ 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): _____

☐ 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. *(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: _____

OR

2. Form I-94 Admission Number: _____

OR

3. Foreign Passport Number: _____

Country of Issuance: _____

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

STOP *Employer Completes Next Page* STOP

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

Additional Information

QR Code - Sections 2 & 3
Do Not Write In This Space

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 Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Native American tribal document
5. For 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.

FORM VA-4

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF TAXATION
PERSONAL EXEMPTION WORKSHEET

(See back for instructions)

1. If you wish to claim yourself, write "1" ..... _____
2. If you are married and your spouse is not claimed on his or her own certificate, write "1" ..... _____
3. Write the number of dependents you will be allowed to claim on your income tax return (do not include your spouse) ..... _____
4. Subtotal Personal Exemptions (add lines 1 through 3) ..... _____
5. Exemptions for age
   (a) If you will be 65 or older on January 1, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse will be 65 or older on January 1, write "1" ..... _____
6. Exemptions for blindness
   (a) If you are legally blind, write "1" ..... _____
   (b) If you claimed an exemption on line 2 and your spouse is legally blind, write "1" ..... _____
7. Subtotal exemptions for age and blindness (add lines 5 through 6) ..... _____
8. Total of Exemptions - add line 4 and line 7 ..... _____

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

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FORM VA-4 EMPLOYEE'S VIRGINIA INCOME TAX WITHHOLDING EXEMPTION CERTIFICATE

Your Social Security Number	Name	
Street Address		
City	State	Zip Code

COMPLETE THE APPLICABLE LINES BELOW

1. If subject to withholding, enter the number of exemptions claimed on:
   (a) Subtotal of Personal Exemptions - line 4 of the Personal Exemption Worksheet ..... _____
   (b) Subtotal of Exemptions for Age and Blindness line 7 of the Personal Exemption Worksheet ..... _____
   (c) Total Exemptions - line 8 of the Personal Exemption Worksheet ..... _____
2. Enter the amount of additional withholding requested (see instructions) ..... _____.
3. I certify that I am not subject to Virginia withholding. I meet the conditions set forth in the instructions ..... (check here) ☐
4. I certify that I am not subject to Virginia withholding. I meet the conditions set forth Under the Service member Civil Relief Act, as amended by the Military Spouses Residency Relief Act ..... (check here) ☐

Signature Date

EMPLOYER: Keep exemption certificates with your records. If you believe the employee has claimed too many exemptions, notify the Department of Taxation, P.O. Box 1115, Richmond, Virginia 23218-1115, telephone (804) 367-8037. Note: Employers may establish a system to electronically receive Forms VA-4 from employees, provided the system meets Internal Revenue Service requirements as specified in § 31.3402(f)(5)-1(c) of the Treasury Regulations (26 CFR).

2601064 Rev. 08/11

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

2023

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 surviving spouse**
☐ **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, other details, 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) Reserved for future use.

(b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; **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 generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate . . . . . ☐

TIP: If you have self-employment income, see page 2.

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 Dependent and Other Credits

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 for qualifying children and other dependents. You may add to this the amount of any other credits. 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 2023 if you meet both of the following conditions: you had no federal income tax liability in 2022 **and** you expect to have no federal income tax liability in 2023. You had no federal income tax liability in 2022 if (1) your total tax on line 24 on your 2022 Form 1040 or 1040-SR is zero (or less than the sum of lines 27, 28, and 29), 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 2023 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, 2024.

Your privacy. 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).

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 income and self-employment taxes through withholding from your wages, you should enter the self-employment income on Step 4(a). Then compute your self-employment tax, divide that tax by the number of pay periods remaining in the year, and include that resulting amount per pay period on Step 4(c). You can also add half of the annual amount of self-employment tax to Step 4(b) as a deduction. To calculate self-employment tax, you generally multiply the self-employment income by 14.13% (this rate is a quick way to figure your self-employment tax and equals the sum of the 12.4% social security tax and the 2.9% Medicare tax multiplied by 0.9235). See Pub. 505 for more information, especially if the sum of self-employment income multiplied by 0.9235 and wages exceeds $160,200 for a given individual.

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.

If you (and your spouse) have a total of only two jobs, you may 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 2023 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. To be accurate, submit a new Form W-4 for all other jobs if you have not updated your withholding since 2019.

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.

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 . . . . . **1** $

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.

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 . . . . . **2a** $

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 . . . . . **2b** $

c Add the amounts from lines 2a and 2b and enter the result on line 2c . . . . . **2c** $

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. **3**

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) . . . . . **4** $

Step 4(b)—Deductions Worksheet *(Keep for your records.)*

1 Enter an estimate of your 2023 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 . . . . . **1** $

2 Enter:
- $27,700 if you're married filing jointly or a qualifying surviving spouse
- $20,800 if you're head of household
- $13,850 if you're single or married filing separately

. . . . . **2** $

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-" . . . . . **3** $

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 . . . . **4** $

5 **Add** lines 3 and 4. Enter the result here and in **Step 4(b)** of Form W-4 . . . . . **5** $

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 territories 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 Surviving Spouse

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	$0	$850	$850	$1,000	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,870
$10,000 - 19,999	0	930	1,850	2,000	2,200	2,220	2,220	2,220	2,220	2,220	3,200	4,070
$20,000 - 29,999	850	1,850	2,920	3,120	3,320	3,340	3,340	3,340	3,340	4,320	5,320	6,190
$30,000 - 39,999	850	2,000	3,120	3,320	3,520	3,540	3,540	3,540	4,520	5,520	6,520	7,390
$40,000 - 49,999	1,000	2,200	3,320	3,520	3,720	3,740	3,740	4,720	5,720	6,720	7,720	8,590
$50,000 - 59,999	1,020	2,220	3,340	3,540	3,740	3,760	4,750	5,750	6,750	7,750	8,750	9,610
$60,000 - 69,999	1,020	2,220	3,340	3,540	3,740	4,750	5,750	6,750	7,750	8,750	9,750	10,610
$70,000 - 79,999	1,020	2,220	3,340	3,540	4,720	5,750	6,750	7,750	8,750	9,750	10,750	11,610
$80,000 - 99,999	1,020	2,220	4,170	5,370	6,570	7,600	8,600	9,600	10,600	11,600	12,600	13,460
$100,000 - 149,999	1,870	4,070	6,190	7,390	8,590	9,610	10,610	11,660	12,860	14,060	15,260	16,330
$150,000 - 239,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$240,000 - 259,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	17,850
$260,000 - 279,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,580	16,780	18,140
$280,000 - 299,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,180	14,380	15,870	17,870	19,740
$300,000 - 319,999	2,040	4,440	6,760	8,160	9,560	10,780	11,980	13,470	15,470	17,470	19,470	21,340
$320,000 - 364,999	2,040	4,440	6,760	8,550	10,750	12,770	14,770	16,770	18,770	20,770	22,770	24,640
$365,000 - 524,999	2,970	6,470	9,890	12,390	14,890	17,220	19,520	21,820	24,120	26,420	28,720	30,880
$525,000 and over	3,140	6,840	10,460	13,160	15,860	18,390	20,890	23,390	25,890	28,390	30,890	33,250

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	$310	$890	$1,020	$1,020	$1,020	$1,860	$1,870	$1,870	$1,870	$1,870	$2,030	$2,040
$10,000 - 19,999	890	1,630	1,750	1,750	2,600	3,600	3,600	3,600	3,600	3,760	3,960	3,970
$20,000 - 29,999	1,020	1,750	1,880	2,720	3,720	4,720	4,730	4,730	4,890	5,090	5,290	5,300
$30,000 - 39,999	1,020	1,750	2,720	3,720	4,720	5,720	5,730	5,890	6,090	6,290	6,490	6,500
$40,000 - 59,999	1,710	3,450	4,570	5,570	6,570	7,700	7,910	8,110	8,310	8,510	8,710	8,720
$60,000 - 79,999	1,870	3,600	4,730	5,860	7,060	8,260	8,460	8,660	8,860	9,060	9,260	9,280
$80,000 - 99,999	1,870	3,730	5,060	6,260	7,460	8,660	8,860	9,060	9,260	9,460	10,430	11,240
$100,000 - 124,999	2,040	3,970	5,300	6,500	7,700	8,900	9,110	9,610	10,610	11,610	12,610	13,430
$125,000 - 149,999	2,040	3,970	5,300	6,500	7,700	9,610	10,610	11,610	12,610	13,610	14,900	16,020
$150,000 - 174,999	2,040	3,970	5,610	7,610	9,610	11,610	12,610	13,750	15,050	16,350	17,650	18,770
$175,000 - 199,999	2,720	5,450	7,580	9,580	11,580	13,870	15,180	16,480	17,780	19,080	20,380	21,490
$200,000 - 249,999	2,900	5,930	8,360	10,660	12,960	15,260	16,570	17,870	19,170	20,470	21,770	22,880
$250,000 - 399,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$400,000 - 449,999	2,970	6,010	8,440	10,740	13,040	15,340	16,640	17,940	19,240	20,540	21,840	22,960
$450,000 and over	3,140	6,380	9,010	11,510	14,010	16,510	18,010	19,510	21,010	22,510	24,010	25,330

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	$620	$860	$1,020	$1,020	$1,020	$1,020	$1,650	$1,870	$1,870	$1,890	$2,040
$10,000 - 19,999	620	1,630	2,060	2,220	2,220	2,220	2,850	3,850	4,070	4,090	4,290	4,440
$20,000 - 29,999	860	2,060	2,490	2,650	2,650	3,280	4,280	5,280	5,520	5,720	5,920	6,070
$30,000 - 39,999	1,020	2,220	2,650	2,810	3,440	4,440	5,440	6,460	6,880	7,080	7,280	7,430
$40,000 - 59,999	1,020	2,220	3,130	4,290	5,290	6,290	7,480	8,680	9,100	9,300	9,500	9,650
$60,000 - 79,999	1,500	3,700	5,130	6,290	7,480	8,680	9,880	11,080	11,500	11,700	11,900	12,050
$80,000 - 99,999	1,870	4,070	5,690	7,050	8,250	9,450	10,650	11,850	12,260	12,460	12,870	13,820
$100,000 - 124,999	2,040	4,440	6,070	7,430	8,630	9,830	11,030	12,230	13,190	14,190	15,190	16,150
$125,000 - 149,999	2,040	4,440	6,070	7,430	8,630	9,980	11,980	13,980	15,190	16,190	17,270	18,530
$150,000 - 174,999	2,040	4,440	6,070	7,980	9,980	11,980	13,980	15,980	17,420	18,720	20,020	21,280
$175,000 - 199,999	2,190	5,390	7,820	9,980	11,980	14,060	16,360	18,660	20,170	21,470	22,770	24,030
$200,000 - 249,999	2,720	6,190	8,920	11,380	13,680	15,980	18,280	20,580	22,090	23,390	24,690	25,950
$250,000 - 449,999	2,970	6,470	9,200	11,660	13,960	16,260	18,560	20,860	22,380	23,680	24,980	26,230
$450,000 and over	3,140	6,840	9,770	12,430	14,930	17,430	19,930	22,430	24,150	25,650	27,150	28,600

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

CHILD SUPPORT AUTHORIZATION

Virginia employers are required by law to notify the Child Support Enforcement Reporting Unit of the Virginia Employment Commission of the identities of all new employees, VA. Code Section § 63.2-1946. If an employee is subject to an income withholding order, employers are required to make appropriate withholdings. The following information will be reported to the Virginia Employment Commission and the Department of Social Services:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____-_____-_____

Are you subject to any income withholding order for child support? ☐ Yes ☐ No

If yes, please provide a copy of the order upon completion of this form.

The employer is authorized to charge a service fee of $5.00 per remittance of child support payments.

The above information shall be kept confidential by the Research Foundation except as required by law. Falsification or material misrepresentation in providing the above information may subject an employee to a withdrawal of the offer of employment, or immediate termination.

Signature below indicates that the employee has read the above and understands what information will be reported to the Virginia Employment Commission upon commencement of employment with the Research Foundation.

_____ _____

Employee's Signature Date

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

HANDBOOK ACKNOWLEDGEMENT

I have been given access to Old Dominion University Research Foundation's Employee Handbook and I understand that it is my responsibility to read and abide by these policies and practices, even if I do not agree with them. I further understand that policies may be updated, revised and posted on the internet at any time; therefore, I should routinely access the electronic Handbook to ensure I am aware of all updates and information. If I have questions about any policy or practice, I understand that I need to ask my supervisor or contact the ODU Research Foundation's Human Resources Department for clarification.

This handbook is not an employment contract. I understand that all employees are at-will employees. As such, you and Old Dominion University Research Foundation have the right to end the employment relationship at any time. The handbook may be accessed on the ODU Research Foundation website at:

http://www.researchfoundation.odu.edu/pdf/handbook.pdf

_____	_____
Printed Name	Signature
_____	_____
ODU E-mail	Date

Original For Personnel File and Employee Provided a Copy

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

Payroll Authorization for Direct Deposit

Name:	UIN:	Date:	
Address:	City:	State:	Zip:
Phone:	E-mail:		

Financial Institution Name:	
Depository Routing Number:	Account Number:
☐ Checking ☐ Savings	Amount: $ Net/All ☐
Financial Institution Name:	
Depository Routing Number:	Account Number:
☐ Checking ☐ Savings	Amount: $
Financial Institution Name:	
Depository Routing Number:	Account Number:
☐ Checking ☐ Savings	Amount: $

REQUIRED Supporting Documentation

It is required to include one of the following for the above accounts for direct deposit to be initiated: a snip/screenshot from the financial institution's website/mobile app, a voided check, or a letter from the financial institution/bank that verifies the routing and account number.

Authorization

By signing below, authorization is given to the Research Foundation to directly deposit my pay in the bank account(s) listed above in the amounts specified. This authorization is to remain in force until the Company has received written authorization from me of its termination or change. I hereby grant the Research Foundation the right to correct any such electronic funds transfer resulting from an erroneous overpayment by debiting my account to the extent of such overpayment.

If incorrect information is provided, resulting in deposits to the wrong account, recovery of funds to the Research Foundation is required before any corrective actions will be taken. This may take up to 10 business days or longer to resolve. If the funds are not recouped, the reissuance/replacement of payroll funds will not be permitted.

Employee Signature:	Date:

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

Employee Emergency Contact Form

Name_____ UIN# _____ Supervisor Name_____

Department _____Work #_____Work Location_____

COMPLETE ONLY THE SECTIONS THAT HAVE CHANGED:

Personal Information:

Employee Address: _____ City, State, Zip _____

Preferred Contact: Cell# _____ Home # _____

Emergency Contact Info:

(1) Name: _____ Relationship _____

Address: _____

City, State, Zip _____

Home Telephone # _____ Cell #_____

Work #_____ Email address _____

(2) Name: _____ Relationship _____

Address: _____

City, State, Zip _____

Home Telephone # _____ Cell #_____

Work #_____ Email address _____

(3) Name: _____ Relationship _____

Address: _____

City, State, Zip _____

Home Telephone # _____ Cell #_____

Work #_____ Email address _____

☐ I have voluntary provided the above contact information and authorize ODU Research Foundation and its representatives to contact any of the above on my behalf in the event of an emergency.

Employee Signature _____ Date _____

OptimaHealth
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401

Optima Health Insurance Company and Optima Health Plan Enrollment Application

TIPS FOR COMPLETING YOUR ENROLLMENT APPLICATION

If you are enrolling your spouse or your children, read this first!

The following situations require that you provide additional information or documentation so that your spouse, or your children up to age 26 can be enrolled in your health plan. Without this information your enrollment and I.D. cards may be delayed.

Coordination of Benefits

Complete Coordination of Benefits Information Page only if you or any of your enrolling family members will have medical coverage in addition to the Optima Health plan (check "Yes" for Section 8 - Additional Coverage).

Continuation of Coverage for Children with an Intellectual Disability or Physical Handicap:

Children over age 26 with an intellectual disability or physical handicap may continue to be eligible for coverage. You may contact Member Services for this form or for additional information.

Check your application carefully to be sure all birthdays and Social Security numbers are correct.

Please make sure to include birth dates and Social Security numbers for each person who will be covered under the Plan.

Optima Health Insurance Company
and Optima Health Plan
4417 Corporation Lane
Virginia Beach, VA 23462
(757) 552-7401 (877) 552-7401

Coordination of Benefits Information Page

* Please retain a copy of this coordination of benefits page for your records.

Applicant's Name: _____ Soc. Sec. #: _____

Date of Birth: _____

NOTE: Complete section 1 and section 3 if you have additional commercial insurance.
Complete section 2 and section 3 if you have Medicare.

SECTION 1 (Commercial Insurance)

Name of other Health Insurance Company: _____

Address: _____

Phone Number: _____

Policy Number: _____ Effective Date: _____

Employer: _____

Group Number: _____

Policyholder's Name: _____

Birthdate: _____

List family members covered by this insurance: _____

SECTION 2 (Medicare Information)

Applicant: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Are you retired: Yes ☐ No ☐ Retirement date: _____

Spouse: _____ Claim#: _____

Hospital Insurance (Part A) Effective Date: _____

Hospital Insurance (Part B) Effective Date: _____

Is your spouse retired: Yes ☐ No ☐ Retirement date: _____

SECTION 3

I hereby certify that except as reported above, no service or payments are provided or are recoverable through any other group health insurance or group health service plan.

	Date:

OptimaHealth

FOR PLAN USE ONLY

Subscriber #: _____

Date:

Optima Health Plan and Optima Health Insurance Company
Large Group (Combined) Enrollment Application

IMPORTANT: Incomplete information will delay enrollment. Please use a ball point pen, press firmly and print clearly.

Section 4

To be completed by employer Group No. _____ **Required** Sub Group No. _____ **Required, if applicable**

O **NEW** O **Open Enrollment** O **Continuation of Coverage** O **C.O.B.R.A.** O **PCP or Address Change**

O **Cancel All** O **Add Dependent/Spouse** O **Cancel Dependent/Spouse** O **Reinstatement**

Employer Name	Effective/Termination Date	Employee's Social Security No.	Hire Date
ODU Research Foundation			

Section 5

Optima Health Plan Selection: HMO/POS Products Underwritten by Optima Health Plan			**Optima Health Insurance Company Plan Selection:** PPO Products Underwritten by Optima Health Insurance Company
☐ Vantage (HMO)	☐ POS	☐ Vantage POSA	☐ Plus (PPO)
☐ Equity Vantage (HMO)	☐ Equity POS	☐ Equity POSA	☐ Equity Plus (PPO)
☐ Design Vantage (HMO)	☐ Design POS	☐ Design POSA	☐ Design Plus (PPO)

Section 6

TO BE COMPLETED BY EMPLOYEE- **(PLEASE PRINT LEGAL NAME)**

Last Name: _____ First Name: _____ Middle Init. _____

Date of Birth: _____ **MO/DAY/YR** Gender: _____ Primary Care Physician & ID #: **Dr.** _____ Current Patient? _____

Address: _____ Primary Language: _____

City/State/Zip: _____

Primary Phone: (_____) _____ Secondary Phone: (_____) _____

Section 7

▶NOTE: Complete this section only if you have selected an Equity plan in Section 5

Health Savings Account (HSA) Administration- If you have chosen the Equity HSA eligible high deductible plan offered through your employer, you are eligible to establish a Health Savings Account (HSA). HealthEquity is Optima Health's preferred vendor for HSA account administration.

Do you want to establish a HSA account? Effective Date: _____

☐ Yes, please DO establish or continue my existing health savings account for me with HealthEquity.

☐ No, please DO NOT establish a health savings account for me with HealthEquity.

Section 8

Additional Coverage- REQUIRED INFORMATION TO BE COMPLETED BY EMPLOYEE FOR ALL PERSONS LISTED BELOW.

Will any of the persons listed below have any other medical health insurance in addition to Optima Health Plan when this coverage takes effect? O Yes O No

If Yes, please complete Sections 1, 2, and 3 on the Coordination of Benefits form attached. If you have other health coverage and have elected a Health Savings Account (HSA), consult your tax advisor on your eligibility for contributing to an HSA.

Section 9

Communication- Please select the method in which you would prefer to receive communications from Optima Health.

	Print	**Electronic**
EOBs: *Explanation of Benefits*	☐	☐
SBC: *Summary of Benefits & Coverage*	☐	☐
Other Communications: *Newsletters etc.*	☐	☐

Email Address: ***(Required for electronic)***

_____

Section 10

Please list below all dependents to be covered by the enrollment application.

(not needed for Plus (PPO) plans)

Social Security No.		Last Name	First Name, MI	Date of Birth MO/DAY/YR	M/F	Primary Care Physician & ID #	Current Patient
	SPOUSE			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	
	CHILD			/ /		DR.	

IF ADDING TO POLICY, DATE OF QUALIFYING EVENT (BIRTH, MARRIAGE, ETC.) _____

Section 11

AUTHORIZATION

I am applying for Optima Health coverage for myself and the family members listed, and agree that once enrolled I and my family members will abide by the provisions of coverage in the Group Contract and Evidence of Coverage or Certificate of Insurance under which we will be enrolled. Optima Health is the trade name for several different companies including Optima Health Plan and Optima Health Insurance Company.

I understand that misrepresentation in answering questions on this application or non-payment of premiums may result in loss of coverage under the Group Health Plan.

I understand that Optima Health may receive and collect personal information from persons other than me. The collected personal or privileged information may be disclosed to third parties without authorization. I understand that I have a right to access and correct all personal information collected about me and that I will receive upon request Optima Health's complete notice of information collection and disclosure practices.

I authorize any physician, hospital, pharmacy, or other provider of health services or supplies, to disclose to Optima Health medical and other information related to eligibility for coverage or a claim for benefits relating to the individuals specified on this application. This authorization shall extend to representatives of Optima Health as needed to fulfill the purposes of the disclosure. I also give Optima Health the right to receive from, and release information to, other insurance companies needed to administer coordination of benefits (COB) provisions under the Group Policy or Group Agreement.

I understand that Optima Health upon receiving information may use it to evaluate eligibility for coverage, a claim for benefits, a request for change in policy benefits, or administer COB. This Authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record.

Any information received by Optima Health pursuant to this application is subject to restrictions on disclosure to others as set forth under state and Federal laws. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this Authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I understand and agree that no benefits shall take effect until this application is received and processed by Optima Health and an Optima Health ID card with an effective date of coverage has been provided.

I understand that it is my responsibility to report and verify to Optima Health any change in the eligibility of myself or my covered family members. If requested, I agree to supply acceptable documentation. I also understand that I am obligated to pay applicable copayments, coinsurance or deductibles at the time services are rendered.

I certify that I have maintained a copy of this completed application for my records. I understand that this application shall become a part of the Group Contract. I further understand that I or my authorized representative may receive a copy of this application upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

I understand that, for the purpose of collecting information in connection with this application, this authorization is valid for 30 months from the date of my signature, and for the purpose of collecting information in connection with a claim for benefits this authorization is valid for the term of coverage of the policy.

Signature of Applicant _____ Date _____

Benefit Administrator _____ Date _____

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Old Dominion Univ. Research Foundation	104994	104994		

Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)
Original COBRA Effective Date if applicable (MM/DD/YYYY)	COBRA Termination Date if applicable (MM/DD/YYYY)

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

Dental Insurance

Select your level of coverage

☐ Employee Only ☐ Employee + Spouse
☐ Employee + Child(ren) ☐ Employee + Spouse + Child(ren)

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) / Date of Birth (MM/DD/YYYY)

_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female
_____ _____ ☐ Male ☐ Female

☐ Check here if you need more lines.

GEF02-1
ADM

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, 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.

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.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing 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 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.

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

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: 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.

GEF09-1
FW

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling.
3. I understand that if I do not enroll for dental coverage during the initial enrollment period, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC

MetLife
Metropolitan Life Insurance Company, New York, NY

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Old Dominion University Research Foundation	**104994**	**104994**		
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security # – –	☐ Male ☐ Female
Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)	

Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life, Basic AD&D, and the Long Term Benefits. I understand that contributions are required for the benefits I select below.

► If you are enrolling during the initial enrollment period, you must complete a Statement of Health form:
- If you are enrolling for Supplemental/Optional Life Insurance and requesting more than $140,000
- If you are enrolling for Dependent Spouse Life Insurance and requesting more than $25,000

► If you are enrolling after the initial enrollment period, you must also complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance

☒ Basic Life [1]

☐ Supplemental/Optional Life [1]

Enter a multiple of $10,000 up to a maximum of the lesser of 5x your Basic Annual Earnings or $500,000. $ _____

☐ Dependent Spouse Life [1,2]

Enter a multiple of $5,000 up to a maximum of $250,000. $ _____

☐ Dependent Child Life [2]

Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic AD&D

☐ Voluntary AD&D

First select your option

☐ Employee only

☐ Employee + Dependents

Then select your level of coverage

Enter a multiple of $10,000 up to a maximum of the lesser of 10x your Basic Annual Earnings or $500,000. $ _____

Disability Income Insurance

☒ Long Term Benefits

[1] Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance.

[2] Amounts will be subject to state limits, if applicable.

GEF02-1
ADM

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) Date of Birth (MM/DD/YYYY)

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

GEF02-1
ADM

FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, 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.

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.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing 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 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.

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

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and 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 files an application containing any false or misleading information is subject to criminal and civil penalties.

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: 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.

GEF09-1
FW

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

Note: Dependent insurance is payable to the Employee.
If you have previously designated a beneficiary under this Group Customer's plan, such beneficiary designation will remain in effect. Any MetLife payment upon your death will be paid in accordance with the records of the recordkeeper for such insurance unless you designate a beneficiary below.
I designate the following person(s) as primary beneficiary(ies) for any MetLife payment upon my death.
I understand I have the right to change this designation at any time.

Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Primary Beneficiary(ies).			**TOTAL:**	**100%**

If all of the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):

Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (MM/DD/YYYY)	Address (Street, City, State, Zip Code)	Share %
Unless otherwise indicated, payment will be made in equal shares to your surviving Contingent Beneficiary(ies).			**TOTAL:**	**100%**

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I was actively at work for at least 20 hours during the 7 calendar days preceding my date of enrollment. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.
4. I understand that if I do not enroll for life or disability coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
5. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
6. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
7. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)

GEF09-1
DEC

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

VISION SERVICE PLAN

ENROLLMENT- CHANGE FORM – Vision Care

Name of Employer: Old Dominion University Research Foundation

Employee Name: _____ UIN: _____
Print Last name, first name, middle initial

☐ Employee Only Coverage
☐ **CHANGE** coverage
☐ **Waive** Employee coverage
☐ Waive Dependent Coverage

DEPENDENT coverage selected:

☐ Employee plus one dependent
☐ Employee plus children
☐ Employee plus family

CHANGE coverage selected:

☐ **ADD** coverage ☐ **DROP** coverage
☐ Employee
☐ Dependent Spouse
☐ Dependent Child(ren)

_____ _____/ _____/ _____
1. Spouse Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____/ _____/ _____
2. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____/ _____/ _____
3. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____/ _____/ _____
4. Child Dependent Name (print: Last, First) Dependent Date of Birth

_____ _____
Employee Signature Date

_____ _____
Effective Date Web Updated

Principal®

Enrollment form

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION TAX-SHELTERED RETIREMENT PLAN

Contract/Plan ID Number: 615916

CTD01321

Principal Life Insurance Company
Des Moines, IA 50306-9394

My personal information (please print with black ink)

Name

Last First MI

Phone number

☐ Home ☐ Mobile

Email address

Address

Street City State Zip Country

Social Security number

- -

Date of birth

/ /

Gender

☐ Male ☐ Female

Marital status

☐ Single ☐ Married

Expected retirement age

Original date of employment

/ /

If you were rehired, complete these dates:

Date of termination

/ /

Date of rehire

/ /

NOTE: The email address you submit will be used for services provided by Principal Financial Group®, unless otherwise elected. We will not provide your email to third parties. For more information, see your privacy policy at principal.com.

Rollover funds

Complete if you would like to consolidate retirement savings.

☐ **Yes!** Help me roll over retirement savings from a previous employer's retirement plan. Call Principal at 1-800-547-7754, Monday - Friday, 7a.m. - 9 p.m. CT.

Please ☐ **call** or ☐ **email** me to discuss my options. My estimated rollover balance is $ _____.

Complete all 3 Steps 1 2 3 to enroll in the retirement savings plan, or to make changes to your contribution percentage.

1 My contributions[A]

Enroll me! (pick one)

☐ I elect to contribute _____% (0% to 100%) or $_____ of my current and future pay per pay period.

☐ I am already enrolled, but I want to change my contribution to _____% (0% to 100%) or $_____ of my current and future pay per pay period.

☐ I choose **not to contribute** to the retirement plan at this time.

Contract/Plan ID Number: 615916

My contributions

[A] Elective deferral contributions are limited to the lesser of the plan or IRS Limit for the current calendar year.

2 My investment choices

Please elect **One of the two choices** by checking the box(es) and completing the applicable information for your choice.

(If you are already enrolled and want to make changes to how future contributions are directed, visit principal.com or call 1-800-547-7754.)

Choice A: Quick Option — Principal LifeTime Funds

☐ I elect a **Quick Option — Principal LifeTime Funds**

I understand contributions will be directed to the plan's Qualified Default Investment Alternative; one of the Principal LifeTime Funds based on the plan's normal retirement date.[1] I have read the plan's QDIA notice and enclosed investment information related to this investment. **I do not want to make another investment election at this time, and this will be treated as my investment option direction.**

Still need help? Log into your account at principal.com for more investment options available to you through your employers retirement plan.

(Please refer to the Investment Option Summary for more information.)

> If you've completed this section, move ahead to **My signature!** 3

[1] Principal LifeTime Funds are available as another way to use an asset allocation strategy that may be right for you. There are other investment options available under the retirement plan, and you should review them all. Reviewing all investment options can help you decide whether you wish to design your own mix of investment options. Please note that your contribution will be directed to the plan's QDIA - Principal LifeTime Funds based on a particular target date or retirement date. If you would rather choose your own mix of investment options, you may do so by completing the Build My Own Portfolio section of this form or visiting principal.com.

Choice B: Build my own portfolio

☐ **I elect the following investment options** (enter percentages below.)

(Please refer to the Investment Option Summary for more information.)

	Elective deferral	Employer
Short-Term Fixed Income		
Fixed Income Guaranteed Option	_____%	_____%
Fixed Income		
BlackRock High Yield Bond K Fund	_____%	_____%
PIMCO Income Institutional Fund	_____%	_____%
Vanguard Inflation-Protected Securities Admiral Fund	_____%	_____%

My investment choices

	Elective deferral	Employer
Vanguard Total Bond Market Index Admiral Fund	_____%	_____%
Balanced/Asset Allocation		
Principal LifeTime Strategic Income Inst Fund	_____%	_____%
Principal LifeTime 2010 Inst Fund	_____%	_____%
Principal LifeTime 2015 Inst Fund	_____%	_____%
Principal LifeTime 2020 Inst Fund	_____%	_____%
Principal LifeTime 2025 Inst Fund	_____%	_____%
Principal LifeTime 2030 Inst Fund	_____%	_____%
Principal LifeTime 2035 Inst Fund	_____%	_____%
Principal LifeTime 2040 Inst Fund	_____%	_____%
Principal LifeTime 2045 Inst Fund	_____%	_____%
Principal LifeTime 2050 Inst Fund	_____%	_____%
Principal LifeTime 2055 Inst Fund	_____%	_____%
Principal LifeTime 2060 Inst Fund	_____%	_____%
Principal LifeTime 2065 Inst Fund	_____%	_____%
SAM Balanced Inst Portfolio	_____%	_____%
SAM Conservative Balanced Inst Portfolio	_____%	_____%
SAM Conservative Growth Inst Portfolio	_____%	_____%
SAM Flexible Income Inst Portfolio	_____%	_____%
SAM Strategic Growth Inst Portfolio	_____%	_____%
Large U.S. Equity		
AQR Large Cap Defensive Style I Fund	_____%	_____%
MFS Value R6 Fund	_____%	_____%
LargeCap S&P 500 Index Inst Fund	_____%	_____%
Vanguard US Growth Admiral Fund	_____%	_____%
Small/Mid U.S. Equity		
MassMutual Select Mid Cap Growth R5 Fund	_____%	_____%
MidCap S&P 400 Index Inst Fund	_____%	_____%
SmallCap S&P 600 Index Inst Fund	_____%	_____%
Vanguard Mid-Cap Value Index Admiral Fund	_____%	_____%
Vanguard Real Estate Index Admiral Fund	_____%	_____%
Vanguard Small Cap Growth Index Admiral Fund	_____%	_____%
Vanguard Small Cap Value Index Admiral Fund	_____%	_____%
International Equity		
American Funds New Perspective R6 Fund	_____%	_____%
American Funds SMALLCAP World R6 Fund	_____%	_____%
DFA Emerging Markets Core Equity I Fund	_____%	_____%
Invesco Oppenheimer International Growth R6 Fund	_____%	_____%
Total of all lines:	**100 %**	**100 %**

Your investment election will be effective when it is received in the Corporate Center of Principal by the close of market. Forms received after the close of market will be processed on the next open market date. If no investment election is received, or contributions are received prior to your investment election, contributions will be directed according to the plan's default investment alternative(s): Principal LifeTime Fund based on your current age and the plan's normal retirement date.

Please log in to principal.com for more details.

> If you've completed this section, move ahead to **My signature!** 3

Contract/Plan ID Number: 615916

3 My signature

Please sign, then give this completed form to your benefits representative.

This agreement applies to amounts earned until changed by me in writing. I understand my plan sponsor may reduce my contributions only when required to meet certain plan limits. I will review all statements regularly and report any discrepancy to Principal immediately.

Signature **Date**

X _____ _____

Be sure you have completed all **3 steps** 1 2 3

Return your completed form to your benefits representative.

Important information

Insurance products and plan administrative services are provided through Principal Life Insurance Co., a member of the Principal Financial Group®, Des Moines, IA 50392. Certain investment options and contract riders may not be available in all states or U.S. commonwealths.

The subject matter in this communication is educational only and provided with the understanding that Principal® is not rendering legal, accounting, or tax advice. You should consult with appropriate counsel or other advisors on all matters pertaining to legal, tax, or accounting obligations and requirements.

This enrollment form content is current as of the production date noted below. If there are any discrepancies between this information and the legal plan document, the legal plan document will govern. If the production date is older than three months or has passed a quarter end, you should contact your plan sponsor or log in to principal.com for current retirement plan and investment option information including a prospectus if applicable. The member companies of the Principal Financial Group® prohibit the manipulation of this enrollment form content. If your plan sponsor elects to provide this enrollment form electronically, Principal® is not responsible for any unauthorized changes.

[A] Sub-Advised Investment Options include Separate Accounts available through a group annuity contract with the Principal Life Insurance Company. Insurance products and plan administrative services, if applicable, are provided by Principal Life Insurance Company a member of the Principal Financial Group, Des Moines, IA 50392. See the fact sheet for the full name of the Separate Account. Certain investment options may not be available in all states or U.S. commonwealths. Principal Life Insurance Company reserves the right to defer payments or transfers from Principal Life Separate Accounts as described in the group annuity contracts providing access to the Separate Accounts or as required by applicable law. Such deferment will be based on factors that may include situations such as: unstable or disorderly financial markets; investment conditions which do not allow for orderly investment transactions; or investment, liquidity, and other risks inherent in real estate (such as those associated with general and local economic conditions). If you elect to allocate funds to a Separate Account, you may not be able to immediately withdraw them.

[1] Principal LifeTime portfolios are available as another way to use an asset allocation strategy that may be right for you. There are other investment options available under the retirement plan, and you should review them all. Reviewing all investment options can help you decide whether you wish to design your own mix of investment options. Please note that your contribution will be directed to the Principal LifeTime portfolio based on a particular target date or retirement date. If you would rather choose your own mix of investment options, you may do so by completing the Build My Own Portfolio section of this form or visiting principal.com.

Your plan sponsor has chosen to make available to you all of the investment options listed on this enrollment form.

Information in this enrollment form should not be construed as investment advice.

PG4711-14 | 10/2018 | 617922-102018

Principal®

Principal Life Insurance Company
Des Moines, IA 50306-9394

Beneficiary form

Contract/Plan ID Number: _____

Location Number: _____

Retirement plan beneficiary designation

CTD01304

You may designate your beneficiary either online at principal.com or by completing the below form.

Follow these steps to name your beneficiary(ies): 1) Complete the Personal Information section. 2) Select one of the beneficiary choices (Choice A, Choice B or Choice C). See Page 3 for more detailed instructions and examples. 3) Name your beneficiary(ies) on Page 2. 4) Sign the form at the bottom of Page 2. 5) Return the beneficiary form to the Principal Financial Group by fax: 866.704.3481, or by mail: Principal Financial Group, P.O. Box 9394, Des Moines, IA 50306-9394.

My personal information (please print with black ink)

Name | **Phone number** | **Social Security number**

Last First MI

Address | **Email address**

Street City State Zip

My beneficiary choices (pick one)

☐ **Choice A: Single participant** (includes widowed, divorced or legally separated)
I am not married and designate the individual(s) named on Page 2 of this form to receive death benefits from the plan.
I understand if I marry, this designation is void one year after my marriage (some plans specify a shorter period).

☐ **Choice B: Married with spouse as sole beneficiary** (spouse's signature is not required)
I am married and designate my spouse named on Page 2 of this form to receive all death benefits from the plan/contract.

☐ **Choice C: Married with spouse not as sole primary beneficiary**
[Spouse's signature **required** — review the Qualified Preretirement Survivor Annuity (QPSA) consent at the end of this form.]

I am married and designate the individual(s) named on Page 2 of this form to receive death benefits in accordance with the plan provisions. **Note:** If you are married and do not name your spouse as the sole primary beneficiary, your spouse must sign the consent below. The signature must be witnessed by a plan representative or notary public. If you are younger than age 35, your spouse must again consent to this in writing at the start of the plan year in which you reach age 35 for this designation to remain effect.

Notice to spouse: In signing, you are also verifying that you have read the QPSA notice and consent on the last page of this form.

☐ **By checking this box,** I agree only to the beneficiary designation on this form. My spouse cannot change the beneficiary without my consent.

Spouse's Signature (must be witnessed by a plan representative or notary public) | **Date**

X _____ / / _____

The spouse appeared before me and signed the consent on: | **Plan Representative or Notary Public Signature** | **Date**

/ / _____ X _____ / / _____

☐ (Check if applicable) I certify that my spouse cannot be located to sign this consent. I will notify the plan sponsor if my spouse is located. **Note:** If your spouse cannot be located, check this box and have it witnessed by the plan representative. It must be established to the satisfaction of the plan representative that your spouse cannot be located.

I certify that spousal consent cannot be obtained because the spouse cannot be located.

Plan Representative Signature | **Date**

X _____ / / _____

Contract/Plan ID Number: _____

Naming my beneficiary(ies)

Before completing, please read the instructions, examples and Qualified Preretirement Survivor Annuity notice on this form. You may name one or more primary and/or contingent beneficiaries. If you need more space to name beneficiaries or name a Trust, Testamentary Trust, or minor children (custodian for minors), please attach a separate list that you have signed and dated. **Note:** Unless otherwise provided, if two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares.

Name [primary beneficiary(ies)] | **Date of birth** | **Relationship** | **Social Security number** | **Percent**

_____ / / _____ - - _____

Address | **City** | **State** | **ZIP**

_____ _____ _____ _____

Name [primary beneficiary(ies)] | **Date of birth** | **Relationship** | **Social Security number** | **Percent**

_____ / / _____ - - _____

Address | **City** | **State** | **ZIP**

_____ _____ _____ _____

If primary beneficiary(ies) is not living, pay death benefits to:

In most circumstances, your contingent beneficiary(ies) will only receive a death benefit if the primary beneficiary predeceases you and the death benefit has not been paid in full.

Name [contingent beneficiary(ies)] | **Date of birth** | **Relationship** | **Social Security number** | **Percent**

_____ / / _____ - - _____

Address | **City** | **State** | **ZIP**

_____ _____ _____ _____

Name [contingent beneficiary(ies)] | **Date of birth** | **Relationship** | **Social Security number** | **Percent**

_____ / / _____ - - _____

Address | **City** | **State** | **ZIP**

_____ _____ _____ _____

Name change

Change my name from: _____ **Change my name to:** _____ **Date** / /

Reason: ☐ Married ☐ Divorce–must attach divorce decree ☐ Other–provide reason: _____

My signature

This designation revokes all prior designations made under the retirement plan.

My signature (required) **Date**

X _____ / /

Under the penalties of perjury, I certify by my signature that all of the information on this beneficiary designation form is true, current and complete.

Contract/Plan ID Number: _____

Instructions

Read carefully before completing this form. To be sure death benefits are paid as you wish, follow these guidelines:

Use Choice A If you are not married.

Use Choice B If you are married and want all death benefits from the plan paid to your spouse. Your spouse does not have to sign the form.

Use Choice C If you are married and want death benefits paid to someone other than your spouse, in addition to your spouse, or to a trust or estate. Your spouse must sign the spouse's consent on this form. This signature must be witnessed by a plan representative or notary public.

You may name one or more contingent beneficiaries. If you need more space to name beneficiaries or name a Trust, Testamentary Trust, or minor children (custodian for minors), please attach a separate list that you have signed and dated.

Be sure you sign and date the form. Keep a copy of this form for your records. If you do not date the form, the designation will become effective the day it's received by your plan sponsor or Principal Life Insurance Company depending upon plan provisions.

If your marital status changes, review your beneficiary designation to be sure it meets these requirements. If your name changes, complete the Name Change section of this form.

Examples of naming beneficiaries

Be sure to use given names such as "Mary M. Doe," not "Mrs. John Doe," and include the address and relationship of the beneficiary or beneficiaries to the participant. If you need more space to name beneficiaries or name a Trust, Testamentary Trust, or minor children (custodian for minors), please attach a separate list that you have signed and dated. The following examples may be helpful to you.

	Name	Relationship	Social Security number	Address	Amount/percent
One primary beneficiary	Mary M. Doe	Sister	###-##-####	XXXXXXXXXXX	100%
Two primary beneficiaries	Jane J. Doe John J. Doe or to the survivor	Mother Father	###-##-#### ###-##-####	XXXXXXXXXXX XXXXXXXXXXX	50% 50%
One primary beneficiary and one contingent	Jane J. Doe if living; otherwise to John J. Doe	Spouse Son	###-##-#### ###-##-####	XXXXXXXXXXX XXXXXXXXXXX	100% 100%
Estate	My Estate				100%
Trust	ABC Bank and Trust Co.	Trustee or successor in trust under (trust name) established (date of trust agreement)		XXXXXXXXXXX	100%
Testamentary trust (Trust established within the participant's will)	John J. Doe/Trust created by the Last Will and Testament of the participant			XXXXXXXXXXX	100%
Children and grandchildren (if beneficiary is a minor, use sample wording shown below)	John J. Doe Jane J. Doe William J. Doe	Son Daughter Son		XXXXXXXXXXX XXXXXXXXXXX XXXXXXXXXXX	33% 33% 33%
	If any of my children predecease me, the surviving children of any such child shall receive in the share their parent would have received, if living. If no child of a deceased child survives, the share of that child of mine shall go to the survivor or survivors of my children, equally.				
Minor children (custodian for minor)	John J. Doe, son, and Jane J. Doe, daughter, equally, or to the survivor. However, if any proceeds become payable to the beneficiary who is a minor as defined by the Iowa Uniform Transfers to Minors Act (UTMA), such proceeds shall be paid to Frank Doe as custodian for John Doe under the Iowa UTMA, and Frank Doe as custodian for Jane Doe under the Iowa UTMA.				

Contract/Plan ID Number: _____

Qualified Preretirement Survivor Annuity (QPSA) notice

If your spouse has a vested account in a retirement plan, federal law requires that you receive a special death benefit if your spouse dies before beginning to receive retirement benefits (or, if earlier, before the beginning of the period for which the retirement benefits are paid).

If you have been married to your spouse for at least one year (some plans may specify a shorter time period), you have the right to receive this payment for your life beginning after your spouse dies. The special death benefit is often called a qualified preretirement survivor annuity (QPSA). This death benefit will automatically be paid in a lump sum rather than as a QPSA if the value of the death benefit is $5,000* or less.

If the lump-sum value of the death benefit is greater than $5,000, the death benefit will be paid in the form of a QPSA. Other options may be available. The actual amount of the QPSA benefit will vary depending on the vested account balance, your age and the cost to purchase the benefit.

Your right to the QPSA benefit provided by federal law cannot be taken away, unless you agree to give up that benefit. If you agree, your spouse can choose to have all or part of the death benefit paid to someone else. The person your spouse chooses to receive the death benefit is usually called the beneficiary. As an example, if you agree, your spouse can have the death benefit paid to his or her children instead of you.

Example: Pat and Robin Doe agree that Robin will not receive the QPSA benefit. Pat and Robin also decide that half of the death benefit that is paid from Pat's vested account will be paid to Robin, and half of the death benefit will be paid to Pat and Robin's child, Chris. The total death benefit is $200 per month. After Pat dies, the plan will pay $100 per month to Robin for the rest of Robin's life. Chris will also receive payments from the plan as long as he lives. Chris will receive less than $100 per month because Chris, being younger than Robin, is expected to receive payments over a longer period.

Your choice to give up the QPSA benefit must be voluntary. It is your personal decision if you want to give up the right. If you sign this agreement, your spouse can choose the beneficiary who will receive the death benefit without telling you and without getting your agreement. Your spouse can change the beneficiary at any time before he or she begins receiving benefits or dies. You have the right to agree to allow your spouse to select only a particular beneficiary. If you want to allow your spouse to select only a particular beneficiary, check the box in Choice C under the My Beneficiary Choices section, which will limit the beneficiary choice to the one designated on this form.

You can agree to give up all or part of the QPSA benefit. If you do so, the plan will pay you the part of the benefit you did not give up, and pay the remaining part of the benefit to the person or persons selected by your spouse.

You can change your mind with respect to giving up your right to the QPSA benefit until the date your spouse dies. After that date, you cannot change this agreement. If you change your mind, you must notify the plan administrator in writing that you want to revoke the consent you give on this form.

You may lose your right to the QPSA benefit if your spouse and you become legally separated or divorced even if you do not sign this agreement. However, if you become legally separated or divorced, you might be able to get a special court order called a qualified domestic relations order (QDRO) that specifically protects your rights to receive the QPSA benefit or that gives you other benefits under this plan. If you are thinking about separating or getting a divorce, you should get legal advice on your rights to benefits from the plan.

QPSA spousal consent and agreement

I understand that I have a right to a QPSA benefit from my spouse's retirement account (see prior section for explanation of QPSA benefit) if my spouse dies prior to receiving retirement benefits—or if earlier, before the beginning of the period for which the retirement benefits are paid. I also understand that if the value of the QPSA benefit is $5,000* or less, the plan will pay the benefit to me in one lump-sum payment.

I agree to give up my right to the QPSA death benefit and to allow my spouse to choose another beneficiary to receive some or all of that benefit. I understand that by signing this agreement, my spouse can choose any beneficiary without telling me and without my consent agreement, unless I limit my spouse's choice to the particular beneficiary by checking the appropriate box in the My Beneficiary Choices section of this form. If I do not check this box, I understand that my spouse can change the beneficiary at any time before retirement benefits begin without telling me and without getting my approval.

I understand I do not have to sign this agreement. I am signing this agreement voluntarily. If I do not sign this agreement, I will receive the QPSA benefit if my spouse dies before beginning to receive retirement benefits—or, if earlier, before the beginning of the period for which the retirement benefits are paid. I understand that if the value of the QPSA benefit is $5,000* or less, the plan will pay the benefit to me in one lump-sum payment.

* Your plan can specify a lower dollar amount.

Contract/Plan ID Number: _____

Important information for spouse

If your spouse has a vested account in a retirement plan, Federal law requires that you will receive the vested account after your spouse dies.

Your right to your spouse's death benefit provided by federal law cannot be taken away unless you agree. If you agree, your spouse can elect to have all or part of the death benefit paid to someone else. Each person your spouse chooses to receive part of the death benefit is called a "beneficiary." For example, if you agree, your spouse can have the death benefit paid to his or her children instead of you.

Your choice must be voluntary. It is your personal decision whether you want to give up your right to your spouse's death benefit. If you do not agree to give up your right to your spouse's death benefit, you should not sign this agreement and you will receive the death benefit after your spouse dies. If you sign this agreement, your spouse can choose the beneficiary who will receive the death benefit without telling you and without getting your agreement. Your spouse can change the beneficiary at any time before the account is paid out. You have the right to agree to allow your spouse to select only a particular beneficiary. If you want to allow your spouse to select only a particular beneficiary, check the box in Choice C under My Beneficiary Choices section, which will limit the beneficiary choice to the one designated on this form.

You can change your mind with respect to giving up your right to the death benefit until the date your spouse dies. After that date, you cannot change this agreement. If you change your mind, you must notify the plan administrator in writing that you want to revoke the consent you give on this form.

Legal separation or divorce may end your right to the death benefit even if you do not sign this agreement. However, if you become legally separated or divorced, you might be able to get a special court order called a qualified domestic relations order (QDRO) that specifically protects your rights to the death benefit. If you are thinking about separating or getting a divorce, you should get legal advice on your rights to benefits from the plan.

Spousal agreement and consent

I understand I have a right to all of my spouse's death benefits after my spouse dies. I agree to give up my right to all or a portion of the death benefits and have all or a portion of them paid to someone else as beneficiary. I understand that by signing this agreement, my spouse can choose the beneficiary of the death benefits without telling me and without getting my agreement. I understand that by signing this agreement, my spouse can change the beneficiary of the death benefits unless I limit my spouse's choice to the particular beneficiary by checking the appropriate box on the My Beneficiary Choices section. I understand that by signing this agreement, I may receive less money than I would have received if I had not signed the agreement, and I may receive nothing from the plan after my spouse dies. I understand that I do not have to sign this agreement. I am signing this agreement voluntarily. I understand that if I do not sign this agreement, then I will receive the death benefit after my spouse dies.

OLD DOMINION UNIVERSITY RESEARCH FOUNDATION

403(b) TAX-SHELTERED RETIREMENT PLAN PAYROLL DEDUCTION AUTHORIZATION

Employee Information:		
Name:	UIN:	Date:
Dept. Phone:	Dept. E-mail:	

The Employee and Employer have entered into this Salary Reduction to obtain for the employee the benefits of section 403(b) of the Internal Revenue Code. It is agreed that, I authorize the Employer to initiate the salary reduction in accordance with the section 403(b) Plan maintained by ODU Research Foundation.

Pre Tax Salary Reduction: ***NOTE: The employee is responsible for compliance with the annual contribution limit and for ensuring the annual salary reduction does not exceed the limits established in sections 403(b) and 415 of the Internal Revenue Code and related regulations.***

☐ I elect to contribute of my current and future pay period the amount of:	$_____
☐ I am already enrolled, but I want to change my contribution to:	$_____
Pay period beginning :	Pay Date:

This authorization will remain in effect until the Employer has received written notification from me of its termination, allowing the Company a reasonable timeframe within which to act. Or, until I complete and sign a new Tax-Sheltered Retirement Plan Payroll Authorization form. This agreement applies to amounts earned until changed by me in writing. I understand my employer may reduce my contributions only when required to meet certain plan limits. I will review all statements regularly and report any discrepancy to ODU Research Foundation immediately.

Employee Signature:	Date:

Choose Your Asset Allocation Investment Options:

All of the contributions made to the retirement plan, will be directed using the investment elective effective at that time. If no investment election is received, or contributions are received prior to your investment election, contributions will be directed according to the plan's default investment option(s). www.principal.com

Cancellation Notification:

I hereby request all Tax-Sheltered Pre-Tax Salary Reduction to stop effective:	Signature:	Date:

Research Foundation Use Only:

Annual Salary:	11% Annualized:	11% per pay period:
Effective Pay Cycle:	Human Resources:	Date:

Research Foundation Verification:

Data Entry: Date:	Payroll: Date:	Payroll Proof: Date:

Old Dominion University Research Foundation

INSURANCE WAIVER

I hereby decline participation in the following insurance plan(s) offered by Old Dominion University Research Foundation:

☐ Health Insurance

☐ Dental Insurance

☐ Vision Insurance

I have been informed of the benefit plans available to me and fully understand that if I elect not to enroll in the plan(s) at this time, I will not be eligible for coverage until the next Annual Open Enrollment period, unless there is a qualifying change in family status (Qualifying Event).

_____ _____

Employee Signature Date

_____ _____

Human Resources Date

_____ _____

Payroll Date