ST. PAUL ELECTRICAL WORKERS HEALTH PLAN
1330 Conway Street • Suite 130
St. Paul, Minnesota 55106
(651) 776-4239

Dear Plan Participant:

In response to your recent claim of disability benefits, we want to advise you of a procedure that is in place to assist this office in the processing of your request. In your packet you will find the following forms that must be completed by you, your employer and your physician.

- Temporary Disability Claim Statement
- Temporary Disability Employer Form
- W-4
- Authorization to Release Protected Health Information
- GENEX Authorization to Disclose Medical Information
- Accident Claim Form

Subrogation/Reimbursement/Lien Agreement **(needed if related to a work, auto or third party injury)**

As a benefit to you and to the fiscal health of the St. Paul Electrical Workers Health Plan, we have enlisted the services of a Disability Management Company: GENEX Services, Inc. GENEX Services, Inc. will be helping us to assess our disability claims and their duration against national standards. Highly trained nurses will review your disability claim form and advise us in appropriate disability durations in the processing of your claim for benefits. The nurse will also make contact with you and will be available to answer any questions you may have regarding your medical treatment or recovery.

This service is in no way intended to delay the fulfillment of your benefit entitlement; however, if you postpone or delay the interview with the GENEX Representative, **your benefit payments will be postponed** until you have completed the interview with GENEX. This program is designed as an added benefit to you to provide you an added resource with your disability. The GENEX Services, Inc. Nurse may communicate with your medical provider to collect any necessary information related to your claim on the Plan's behalf.

Should you have any questions, please contact the Benefit Office at (952) 851-5949
Please feel free to Fax # 651-776-9973 or Email spewbenefits@wilson-mcshane.com

Thank you for your cooperation. We hope you recover from your disability quickly.

PLEASE REMEMBER ALL PAPERWORK MUST BE RETURNED BEFORE DISABILITY CAN START!
Completed disability paperwork received by noon on Thursday will be processed for payment Friday

Disability Benefit Plan

Only Participants (bargaining and Non-Bargaining Unit Employees) on whose behalf contributions are made to the Plan by the employer specifically for the Disability Benefit Plan are eligible for disability benefits.

General Provisions

The Trustees may require a second Doctor's opinion before commencing benefit payments for Your Temporary Total Disability or Total and Permanent Disability. Benefits consist of income replacement benefits and free medical coverage.

The second Doctor will be selected by the Board of Trustees. If the first two Doctors do not agree, the opinion of a third Doctor mutually agreeable to the first two Doctors will be required. If the second and third Doctors determine that You are not disabled, no benefits will be paid.

The Plan will pay for any required second or third opinions at one hundred percent (100%).

Disability Benefits	Employee Only
Temporary Total Disability Income Replacement Benefit • Maximum Weekly Benefit • Maximum Duration Benefits Begin	 $600 up to 26 weeks On first day of Injury or eighth day for an Illness or first day if hospitalization or with surgery
Own Occupation Temporary Disability Income Replacement Benefit • Weekly Benefit • Maximum Duration	 Half the benefit received for Temporary Total Disability twenty-four (24) months
Permanent Total Disability Income Replacement Benefit • Monthly Benefit • Maximum Total Benefit	 $325 $20,500
Medical Coverage During Temporary Disability	Free for up to thirty (30) months
Medical Coverage During Permanent Disability	Free

Weekly Benefit for Temporary Total Disability of the Participant

Temporary Total Disability means that You are unable to engage in the usual and customary duties of Your own occupation due to bodily Injury or Illness. The Trustees will pay a weekly benefit if You are ill or injured and qualify for Temporary Total Disability coverage. The benefit varies according to Your normal employment classification, as follows:

- If Your classification is Journeyman Inside Wireman, the benefit paid is Six Hundred Dollars ($600) per week (One Hundred Twenty Dollars ($120) per day).
- All other classifications will receive a benefit based on Your wage at the time of the disability, as a percent of the Construction Agreement wage in effect, multiplied by the Journeyman Inside Wireman benefit, noted above, to a maximum benefit of Six Hundred Dollars ($600) per week.

You are eligible for the benefit, up to a maximum of twenty-six (26) weeks per period of disability, if employer contributions or disability benefit payments for the Disability Benefit Plan are made on Your behalf to the Trust Fund, and You are under the care of a Physician or Chiropractor.

Benefits are paid according to these rules:

- Due to an Acute Injury, the benefit begins with the *first (1st)* day of the disability.
- Due to an Illness, the benefit begins with the *eighth (8th)* day of the disability. The benefit is payable, however, from the first day of an Illness if You are hospitalized or undergo surgery.
- No benefit will be paid if:
    - Illness or Injury begins after You are seventy (70) years old; or
    - Illness or Injury begins while You are unemployed. (If You are a bargaining unit employee and unemployed through no fault of Your own and suffer an Illness or Injury that disqualifies You from unemployment compensation, You will be eligible for temporary disability benefits.); or
    - You have not been seen and treated personally by a Physician or chiropractor; or
    - You have not submitted the proper disabling statement; or
    - A disability is caused by Chemical Dependency for which You are currently in treatment; or
    - Any provision of the Plan specifically excludes coverage of treatment for Your Illness or Injury; or
    - You have not enrolled in and complied with the disability management program as established by the Trustees; or
    - You are receiving benefits under Workers' Compensation Law.
        - One-fifth of the weekly benefit will be paid for each day of total disability, not to exceed a maximum of five (5) days during any week of disability.
        - If You begin receiving benefits, and then return to full-time active work for less than two weeks before stopping work again because of the same disability, the time spent on temporary disability will be considered one benefit period.
        - If, however, the second period of disability is a result of a different Illness or Injury, and You spend at least one full day in active employment, it will be considered two separate benefit periods.
        - If You work less than one full day between times of disability, it will be considered one benefit period, unless the Trustees determine that the other permanent disability requires extended coverage.
        - If You are receiving other disability payments, or sick leave pay, during Your period of disability, Your weekly benefit will be reduced by the amount by which Your other disability payments exceed twice the amount of this Plan's disability benefit. If the total of Your other payments do not exceed the amount of this Plan's disability benefit there will be no reduction.
- You must file a Return-to-Work form (available at the Fund Office) no later than five (5) days after the date You returned to work. If You fail to file this form and properly notify the Plan of the date You returned to work, You will be assessed an administrative fee for processing any benefit refunds resulting from overpayment of benefits.

Job Related Disability

If Your period of disability is shorter than that which qualifies for Workers' Compensation, and if You are under the care of a Physician or Chiropractor, You will receive Fifty Dollars ($50) per day for up to three (3) days, as compensation for lost wages.

If You miss a day of work for treatment by a Physician or Chiropractor after the first day of a job-related Injury, You will be compensated at Your regular hourly rate, not to exceed one-fifth (1/5) of Your normal weekly disability benefits for any day or part of a day.

Own Occupation Temporary Disability of the Participant

If You exhaust the benefits under Temporary Total Disability Income Replacement Benefit and are still unable to engage in the usual and customary duties of Your own occupation because of an Injury or Illness, You may be eligible to receive Own Occupation Temporary Disability Benefits. Own Occupation Temporary Disability means You have not suffered a Total Permanent Disability, have exhausted the Temporary Disability benefits in Part A and You are still unable to engage in the usual and customary duties of Your own occupation due to bodily Injury or Illness.

The Plan will pay a weekly benefit of 50% of the benefit You were receiving under Part A when You qualify for the Own Occupation Temporary Disability. The weekly benefit payments will continue until the earlier of any of the following events:

- You are released to return to work in Your own occupation.
- The Trustees determine that You have a Total Permanent Disability.
- You have received the maximum benefit of twenty-four (24) consecutive months of Own Occupation Temporary Disability.

You must follow these rules:

- You must continue to participate in the disability management programs as established by the Trustees.
- You must file a Return-to-Work form (available at the Fund Office) no later than five days after the date You returned to work. If You fail to file this form and properly notify the Plan of the date You returned to work, You will be assessed an administrative fee for processing any benefit refunds resulting from overpayment of benefits.

If You are receiving other disability benefits or sick leave pay, during Your period of disability, Your weekly benefit will be reduced by the amount by which Your other disability payments exceed twice the amount of the Plan's disability benefit. If the total of Your other payments do not exceed the amount of this Plan's disability benefit, there will be no reduction.

You may earn up to two times Your disability benefit from a job without reduction of Your disability benefit provided the job is not in Your own occupation. Your weekly benefit will be reduced to the extent such earnings exceed twice Your disability benefit.

Permanent Total Disability Benefit for the Participant

You are eligible for Permanent Total Disability Benefits if all of the following apply:

- You have a minimum of one hundred twenty (120) consecutive months of participation in this Plan immediately preceding the date of disability. However, if You are a Regular Employee and are unemployed due to a lack of work, then periods of such unemployment will count toward the one

hundred twenty (120) consecutive months, as long as You can provide verification that You did not leave the industry, remained properly registered and available for work, and that You did not refuse work.

- o You have exhausted the benefits provided for Temporary Total Disability Income Replacement Benefits.
- o You have furnished medical proof of Your permanent and total disability that is satisfactory to the Trustees.
- o You have provided information from time to time about Your status, as required by the Trustees.
- o The benefit amount is Three Hundred Twenty-five Dollars ($325) per month. This benefit will be paid until the earliest of the following:
- o You receive Permanent Total Disability Benefit payments from the Disability Benefit Plan totaling Twenty Thousand Five Hundred Dollars ($20,500); or
- o You are no longer permanently and totally disabled; or
- o You become eligible to receive benefits from:
    - The St. Paul Electrical Construction Pension Plan for Early Retirement, if the disability occurred before July 1, 1997.
    - Any other pension plan (except the National Electrical Benefit Fund); or
    - You die.

Medical Coverage While Disabled – Regular Employee

If You are a Regular Employee:

- Temporary Total Disability. If You have a Temporary Total Disability, You are entitled to free medical benefits coverage (medical, dental, and vision) for up to a maximum of thirty (30) months or the earlier of: (1) being released to return to work; (2) no longer receiving short-term disability benefits under the state laws governing Workers' Compensation or from this Plan; or (3) obtaining Permanent Total Disability status.
- Permanent Total Disability. You are entitled to free medical benefits coverage (medical, dental, and vision) unless You are eligible for benefits from the Retiree Medical Funding Plan.

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TEMPORARY DISABILITY CLAIM STATEMENT

Participant Name: ______________________________ Social Security #: XXX-XX-__________

Participant Cell # ________________________ Employer ______________________________

Nature of Disability: ____ Date: ________________

□ Accident □ Illness □ Occupational □ Non-Occupational

How and where disability occurred: ____

Have you applied for or are collecting Social Security Disability? Yes ______ No _______

Are You Retired? Yes_______ No_______

I hereby acknowledge that if I am unemployed, I am not receiving any unemployment compensation; further, failure to supply true, correct and complete information will result in loss of benefits. As well as I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to myself which may have a bearing on the benefits under this or any other plan providing benefits or services

Participant's Signature: _____________________________________ Date: ________________

I would like my benefit check to be: □ Mailed to my home □ Deposited in my St Paul FCU account

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THIS PORTION IS TO BE COMPLETED BY THE PHYSICIAN ONLY. IF ANY PART OF THIS SECTION IS COMPLETED BY PARTICIPANT IT WILL DISQUALIFY THIS CLAIM

Name of Patient: ________________________________ Date of initial consultation: __________

Diagnosis: ____

□ Accident □ Illness □ Occupational □ Non-Occupational

Name of Hospital: _________________________ Date of admission: _______________________

Patient was continuously disabled (unable to do regular work) **from: __/__/___ to: __/__/___**

mo./date/yr. mo./date/yr.

(There must be dates in the above section in order to start & pay member's disability)

Physician's Name (please print): ____

Physician's Office Name (please print): ____

Physician's Address: ____________________________ Phone: _____________________________

Physician's Signature: ________________________________ Date: _____________________

Please feel free to Fax # 651-776-9973 or Email spewbenefits@wilson-mcshane.com

ELECTRICIAN

JOB DESCRIPTION

General

An Electrician performs the installation and maintenance of electrical systems for heat, light and power in buildings in the course of construction, renovation or maintenance. Physical strength and mobility and mental alertness are required to complete the typical duties of an Electrician.

Mental Awareness

The Electrician must be able to:

- Understand verbal instructions and heed verbal warnings or warning signals
- Perform common mathematical problems and use formulas
- Read complex technical documents
- Understand graphs, charts and diagrams
- Communicate orally with others
- Develop alternative solutions to a problem and choose the best alternative

Physical Abilities

The Electrician must be able to:

- Work with both hands and manipulate small wires and objects
- Coordinate body movements when using tools and equipment
- Operate two-handed equipment; such as, drills, saws and other power tools
- Climb, maintain balance and perform construction tasks on ladders at heights up to 26 feet, or higher
- Reach, stretch or lift over head to position equipment while maintaining balance
- Bend or twist the body or work in unusual positions
- Traverse irregular surfaces while maintaining balance
- Lift, move or carry objects up to 25 pounds frequently
- Lift, move or carry objects 25-50 pounds occasionally
- Lift, hold or install objects over head up to 25 pounds frequently
- Work outdoors or indoors in extreme weather or temperature conditions
- Apply muscular force, push or pull objects and equipment into position
- Walk, stand, bend twist, squat, kneel and sit frequently
- Perform physical tasks all day without becoming overly tired

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TEMPORARY DISABILITY EMPLOYER FORM

Please complete this report IMMEDIATELY and return to the St. Paul Electrical Workers Health Plan. DO NOT hold until employee has returned to work. Please mail to address above or email to spewbenefits@wilson-mcshane.com. Any questions please call the Benefit Office at 952-851-5949

Employer Name: ____

Employee Name: ____

Employee Hourly Rate of Pay $: ___________________________________

Date Employee Last Worked: _____________________________________

Nature of Disability ☐ Accident ☐ Illness
☐ Occupational ☐ Non-Occupational

____
Signature of Employer's Representative Date

Email address: ____

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

2024

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, and when to use the estimator at *www.irs.gov/W4App*.

Step 2: Multiple Jobs or Spouse Works

Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs.

Do **only one** of the following.

(a) Use the estimator at *www.irs.gov/W4App* for most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; **or**

(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 . . . . ☐

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 2024 if you meet both of the following conditions: you had no federal income tax liability in 2023 **and** you expect to have no federal income tax liability in 2024. You had no federal income tax liability in 2023 if (1) your total tax on line 24 on your 2023 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 2024 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, 2025.

Your privacy. Steps 2(c) and 4(a) ask for information regarding income you received from sources other than the job associated with this Form W-4. If you have concerns with providing the information asked for in Step 2(c), you may choose Step 2(b) as an alternative; if you have concerns with providing the information asked for in Step 4(a), you may enter an additional amount you want withheld per pay period in Step 4(c) as an alternative.

When to use the estimator. Consider using the estimator at *www.irs.gov/W4App* if you:

1. Expect to work only part of the year;

2. Receive dividends, capital gains, social security, bonuses, or business income, or are subject to the Additional Medicare Tax or Net Investment Income Tax; or

3. Prefer the most accurate withholding for multiple job situations.

Self-employment. Generally, you will owe both income and self-employment taxes on any self-employment income you receive separate from the wages you receive as an employee. If you want to pay these taxes through withholding from your wages, use the estimator at *www.irs.gov/W4App* to figure the amount to have withheld.

Nonresident alien. If you're a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Specific Instructions

Step 1(c). Check your anticipated filing status. This will determine the standard deduction and tax rates used to compute your withholding.

Step 2. Use this step if you (1) have more than one job at the same time, or (2) are married filing jointly and you and your spouse both work.

Option **(a)** most accurately calculates the additional tax you need to have withheld, while option **(b)** does so with a little less accuracy.

Instead, 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 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 2024 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; or, you can use the online withholding estimator at *www.irs.gov/W4App*.

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 2024 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:
- $29,200 if you're married filing jointly or a qualifying surviving spouse
- $21,900 if you're head of household
- $14,600 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	$780	$850	$940	$1,020	$1,020	$1,020	$1,020	$1,020	$1,020	$1,370
$10,000 - 19,999	0	780	1,780	1,940	2,140	2,220	2,220	2,220	2,220	2,220	2,570	3,570
$20,000 - 29,999	780	1,780	2,870	3,140	3,340	3,420	3,420	3,420	3,420	3,770	4,770	5,770
$30,000 - 39,999	850	1,940	3,140	3,410	3,610	3,690	3,690	3,690	4,040	5,040	6,040	7,040
$40,000 - 49,999	940	2,140	3,340	3,610	3,810	3,890	3,890	4,240	5,240	6,240	7,240	8,240
$50,000 - 59,999	1,020	2,220	3,420	3,690	3,890	3,970	4,320	5,320	6,320	7,320	8,320	9,320
$60,000 - 69,999	1,020	2,220	3,420	3,690	3,890	4,320	5,320	6,320	7,320	8,320	9,320	10,320
$70,000 - 79,999	1,020	2,220	3,420	3,690	4,240	5,320	6,320	7,320	8,320	9,320	10,320	11,320
$80,000 - 99,999	1,020	2,220	3,620	4,890	6,090	7,170	8,170	9,170	10,170	11,170	12,170	13,170
$100,000 - 149,999	1,870	4,070	6,270	7,540	8,740	9,820	10,820	11,820	12,830	14,030	15,230	16,430
$150,000 - 239,999	1,960	4,360	6,760	8,230	9,630	10,910	12,110	13,310	14,510	15,710	16,910	18,110
$240,000 - 259,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$260,000 - 279,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,190
$280,000 - 299,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,790	16,990	18,380
$300,000 - 319,999	2,040	4,440	6,840	8,310	9,710	10,990	12,190	13,390	14,590	15,980	17,980	19,980
$320,000 - 364,999	2,040	4,440	6,840	8,310	9,710	11,280	13,280	15,280	17,280	19,280	21,280	23,280
$365,000 - 524,999	2,720	6,010	9,510	12,080	14,580	16,950	19,250	21,550	23,850	26,150	28,450	30,750
$525,000 and over	3,140	6,840	10,540	13,310	16,010	18,590	21,090	23,590	26,090	28,590	31,090	33,590

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	$240	$870	$1,020	$1,020	$1,020	$1,540	$1,870	$1,870	$1,870	$1,870	$1,910	$2,040
$10,000 - 19,999	870	1,680	1,830	1,830	2,350	3,350	3,680	3,680	3,680	3,720	3,920	4,050
$20,000 - 29,999	1,020	1,830	1,980	2,510	3,510	4,510	4,830	4,830	4,870	5,070	5,270	5,400
$30,000 - 39,999	1,020	1,830	2,510	3,510	4,510	5,510	5,830	5,870	6,070	6,270	6,470	6,600
$40,000 - 59,999	1,390	3,200	4,360	5,360	6,360	7,370	7,890	8,090	8,290	8,490	8,690	8,820
$60,000 - 79,999	1,870	3,680	4,830	5,840	7,040	8,240	8,770	8,970	9,170	9,370	9,570	9,700
$80,000 - 99,999	1,870	3,690	5,040	6,240	7,440	8,640	9,170	9,370	9,570	9,770	9,970	10,810
$100,000 - 124,999	2,040	4,050	5,400	6,600	7,800	9,000	9,530	9,730	10,180	11,180	12,180	13,120
$125,000 - 149,999	2,040	4,050	5,400	6,600	7,800	9,000	10,180	11,180	12,180	13,180	14,180	15,310
$150,000 - 174,999	2,040	4,050	5,400	6,860	8,860	10,860	12,180	13,180	14,230	15,530	16,830	18,060
$175,000 - 199,999	2,040	4,710	6,860	8,860	10,860	12,860	14,380	15,680	16,980	18,280	19,580	20,810
$200,000 - 249,999	2,720	5,610	8,060	10,360	12,660	14,960	16,590	17,890	19,190	20,490	21,790	23,020
$250,000 - 399,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$400,000 - 449,999	2,970	6,080	8,540	10,840	13,140	15,440	17,060	18,360	19,660	20,960	22,260	23,500
$450,000 and over	3,140	6,450	9,110	11,610	14,110	16,610	18,430	19,930	21,430	22,930	24,430	25,870

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	$510	$850	$1,020	$1,020	$1,020	$1,020	$1,220	$1,870	$1,870	$1,870	$1,960
$10,000 - 19,999	510	1,510	2,020	2,220	2,220	2,220	2,420	3,420	4,070	4,070	4,160	4,360
$20,000 - 29,999	850	2,020	2,560	2,760	2,760	2,960	3,960	4,960	5,610	5,700	5,900	6,100
$30,000 - 39,999	1,020	2,220	2,760	2,960	3,160	4,160	5,160	6,160	6,900	7,100	7,300	7,500
$40,000 - 59,999	1,020	2,220	2,810	4,010	5,010	6,010	7,070	8,270	9,120	9,320	9,520	9,720
$60,000 - 79,999	1,070	3,270	4,810	6,010	7,070	8,270	9,470	10,670	11,520	11,720	11,920	12,120
$80,000 - 99,999	1,870	4,070	5,670	7,070	8,270	9,470	10,670	11,870	12,720	12,920	13,120	13,450
$100,000 - 124,999	2,020	4,420	6,160	7,560	8,760	9,960	11,160	12,360	13,210	13,880	14,880	15,880
$125,000 - 149,999	2,040	4,440	6,180	7,580	8,780	9,980	11,250	13,250	14,900	15,900	16,900	17,900
$150,000 - 174,999	2,040	4,440	6,180	7,580	9,250	11,250	13,250	15,250	16,900	18,030	19,330	20,630
$175,000 - 199,999	2,040	4,510	7,050	9,250	11,250	13,250	15,250	17,530	19,480	20,780	22,080	23,380
$200,000 - 249,999	2,720	5,920	8,620	11,120	13,420	15,720	18,020	20,320	22,270	23,570	24,870	26,170
$250,000 - 449,999	2,970	6,470	9,310	11,810	14,110	16,410	18,710	21,010	22,960	24,260	25,560	26,860
$450,000 and over	3,140	6,840	9,880	12,580	15,080	17,580	20,080	22,580	24,730	26,230	27,730	29,230

DEPARTMENT OF REVENUE

2024 W-4MN, Minnesota Withholding Allowance/Exemption Certificate

Employees

Complete Form W-4MN so your employer can withhold the correct Minnesota income tax from your pay. Consider completing a new Form W-4MN each year and when your personal or financial situation changes. If no Form W-4MN is in effect, the number of withholding allowances claimed will be zero.

First Name and Initial	Last Name	Social Security Number
Permanent Address		**Marital Status** ***(Check one):*** ☐ Single; Married, but legally separated; or Spouse is a nonresident alien ☐ Married ☐ Married, but withhold at higher Single rate
City	State / ZIP Code	

Complete Section 1 OR Section 2, then sign the bottom and give the completed form to your employer.

☐ Section 1 — Determining Minnesota Allowances

A Enter "1" if no one else can claim you as a dependent . . . . **A** ________

B Enter "1" if any of the following apply: . . . . **B** ________

- You are single and have only one job
- You are married, have only one job, and your spouse does not work
- Your wages from a second job or your spouse's wages are $1500 or less

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

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

E Enter "1" if you will use the filing status Head of Household *(see instructions)*. . . . . **E** ________

F Add steps A through E. If you plan to itemize deductions on your 2024 Minnesota income tax return, you may also complete the Itemized Deductions and Additional Income Worksheet. . . . . **F** ________

1 **Minnesota Allowances.** Enter Step F from Section 1 above or Step 10 of the Itemized Deductions Worksheet . . . . **1** ________

2 Additional Minnesota withholding you want deducted for each pay period *(see instructions)* . . . . **2** $________

☐ Section 2 — Exemption From Minnesota Withholding

Complete Section 2 if you claim to be exempt from Minnesota income tax withholding *(see Section 2 instructions for qualifications)*. If applicable, check one box below to indicate why you believe you are exempt:

☐ **A** I meet the requirements and claim exempt from both federal and Minnesota income tax withholding

☐ **B** Even though I did not claim exempt from federal withholding, I claim exempt from Minnesota withholding, because:

- I had no Minnesota income tax liability last year
- I received a refund of all Minnesota income tax withheld
- I expect to have no Minnesota income tax liability this year

☐ **C** All of these apply:

- My spouse is a military service member assigned to a military location in Minnesota
- My domicile (legal residence) is in another state
- I am in Minnesota solely to be with my spouse. My state of domicile is ________________

☐ **D** I am an American Indian that resides and works on a reservation for which I am enrolled *(see instructions)*.
Enter the reservation name: ________________
Enter your Certificate of Degree of Indian Blood (CDIB)/Enrollment number: ________________

☐ **E** I am a member of the Minnesota National Guard or an active-duty U.S. military member and claim exempt from Minnesota withholding on my military pay

☐ **F** I receive a military pension or other military retirement pay as calculated under U.S. Code, title 10, sections 1401 through 1414, 1447 through 1455, and 12733, and I claim exempt from Minnesota withholding on this retirement pay

I certify that all information provided in Section 1 ***OR*** *Section 2 is correct. I understand there is a $500 penalty for filing a false Form W-4MN.*

Employee's Signature	Date	Daytime Phone Number

Employees: Give the completed form to your employer.

Employers

See the employer instructions to determine if you must send a copy of this form to the Minnesota Department of Revenue. If required, enter your information below and mail this form to the address in the instructions. (Incomplete forms are considered invalid.) We may assess a $50 penalty for each required Form W-4MN not filed with us. Keep a copy for your records.

Name of Employer	Minnesota Tax ID Number	Federal Employer ID Number (FEIN)

Address	City	State	ZIP Code

DEPARTMENT OF REVENUE

Form W-4MN Instructions for Employees

Complete this form for your employer to calculate the amount of Minnesota income tax to be withheld from your pay.

When must I complete Form W-4MN?

Complete Form W-4MN if any of these apply:

- You begin employment
- You change your filing status
- You reasonably expect to change your filing status in the next calendar year
- Your personal or financial situation changes
- You claim exempt from Minnesota withholding (see Section 2 instructions for qualifications)

If you have not had sufficient Minnesota income tax withheld from your wages, we may assess penalty and interest when you file your state income tax return.

Note: Your employer may be required to submit a copy of your Form W-4MN to the Minnesota Department of Revenue. You may be subject to a $500 penalty if you provide a false Form W-4MN.

You must enter your Social Security Number for this Form W-4MN to be valid.

What if I have completed federal Form W-4?

If you completed a 2024 Form W-4, you must complete Form W-4MN to determine your Minnesota withholding allowances.

What if I am exempt from Minnesota withholding?

If you claim exempt from Minnesota withholding, complete only Section 2 of Form W-4MN and sign and date the form to validate it. If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year in which you claim an exemption from Minnesota withholding.

You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

What if I am a nonresident alien for U.S. income taxes?

If you are a nonresident alien, you are not allowed to claim exempt from withholding. You will check the single box for marital status regardless of your actual marital status and may enter one personal allowance on Step A of Section 1. Enter zero on steps B, C, and E of Section 1.

If you are resident of Canada, Mexico, South Korea, or India, and are allowed to claim dependents, enter the number of dependents on Step D.

Section 1 — Minnesota Allowances Worksheet

Complete Section 1 to find your allowances for Minnesota withholding tax. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

If you expect to owe more income tax for the year than will be withheld, you can claim fewer allowances or request additional Minnesota withholding from your wages. Enter the amount of additional Minnesota income tax you want withheld on line 2 of Section 1.

Nonwage Income

Consider making estimated payments if you have a large amount of “nonwage income.” Nonwage income (other than tax-exempt income) includes interest, dividends, net rental income, unemployment compensation, gambling winnings, prizes and awards, hobby income, capital gains, royalties, and partnership income.

Two Earners or Multiple Jobs

If your spouse works or you have more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4MN. Usually, your withholding will be more accurate when all allowances are claimed on the Form W-4MN for the highest paying job and zero allowances are claimed on the others.

Head of Household Filing Status

You may claim Head of Household as your filing status if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependents. Enter “1” on Step E if you may claim Head of Household as your filing status on your tax return.

What if I itemize deductions on my Minnesota return or have other nonwage income?

Use the Itemized Deductions and Additional Income Worksheet to find your Minnesota withholding allowances. Complete Section 1 on page 1, then follow the steps in the worksheet on the next page to find additional allowances.

Continued

Itemized Deductions and Additional Income Worksheet

1 Enter an estimate of your 2024 Minnesota itemized deductions. For 2024, you may have to reduce your itemized deductions if your income is over $232,500 ($116,250 for Married Filing Separately).. . . . . ________
2 Enter one of the following based on your filing status: . . . . ________
   a. $29,150 if Married Filing Jointly
   b. $21,900 if Head of Household
   c. $14,575 if Single or Married Filing Separately
3 Subtract step 2 from step 1. If zero or less, enter 0 . . . . ________
4 Enter an estimate of your 2024 additional standard deduction (from page 11 of the Form M1 instructions) . . . . ________
5 Add steps 3 and 4 . . . . ________
6 Enter an estimate of your 2024 taxable nonwage income . . . . ________
7 Subtract step 6 from step 5. If zero, enter 0. If less than zero, enter the amount in parentheses.. . . . . ________
8 Divide the amount on step 7 by $5,050. If a negative amount, enter in parentheses. Do not include fractions . . . . ________
9 Enter the number on step F of Section 1 on page 1 . . . . ________
10 Add step 8 and 9 and enter the total here. If zero or less, enter 0. Enter this amount on line 1 of page 1. . . . . ________

Section 2 — Minnesota Exemption

Your employer will not withhold Minnesota taxes from your pay if you are exempt from Minnesota withholding. You cannot claim exempt from withholding if all of these apply:

- Another person can claim you as a dependent on their federal tax return
- Your annual income exceeds $1,100
- Your annual income includes more than $350 of unearned income

Box A

Check box A of Section 2 to claim exempt if all of these apply:

- You meet the requirements to be exempt from federal withholding
- You had no Minnesota income tax liability in the prior year and received a full refund of Minnesota tax withheld
- You expect to have no Minnesota income tax liability for the current year

Box B

Check box B of Section 2 if you are not claiming exempt from federal withholding, but meet the second and third requirements for box A.

Box C

Check box C in Section 2 to claim exempt if all of these apply:

- You are the spouse of a military member assigned to duty in Minnesota
- You and your spouse are domiciled in another state
- You are in Minnesota solely to be with your active duty military spouse member

Boxes D-F

If you receive income from the following sources, it is exempt from Minnesota withholding. Your employer will not withhold Minnesota tax from that income when you check the appropriate box in Section 2.

- **Box D:** You receive wages as a member of an American Indian tribe living and working on the reservation of which you are an enrolled member. Enter the name of your reservation and your Certificate of Degree of Indian or Alaskan Blood (CDIB) number/enrollment number. **Members of the Minnesota Chippewa Tribe** can exclude income regardless of which Minnesota Chippewa Tribe reservation you live and work on. This affects members of these tribes:
  - Mille Lacs
  - Nett Lake (Bois Forte)
  - Fond du Lac
  - Leech Lake
  - White Earth
  - Grand Portage
- **Box E:** You receive wages for Minnesota National Guard (MNG) pay or for active duty U.S. military pay. MNG and active duty U.S. military members can claim exempt from Minnesota withholding on these wages, even if they are taxable federally. For more information, see Income Tax Fact Sheet 5, *Military Personnel*.
- **Box F:** You receive a military pension or other military retirement pay calculated under U.S. Code title 10, sections 1401 through 1414, 1447 through 1455, and 12733. You may claim exempt from Minnesota withholding on this income even if it is taxable federally.

Note: You may not want to claim exempt if you (or your spouse if filing a joint return) expect to have other forms of income subject to Minnesota tax and you want to avoid owing tax at the end of the year.

If you complete Section 2, you must complete a new Form W-4MN by February 15 in each following year.

Nonresident Alien

If you are a nonresident alien for federal tax purposes, do not complete Section 2. See IRS Publication 519, *U.S. Tax Guide for Aliens*.

Continued

Line 2 — Additional Minnesota Withholding

If you would like an additional amount of tax to be deducted per payment period, enter the amount on line 2. Do not enter a percentage of the payment you want to be deducted.

Use of Information

All information on Form W-4MN is private by state law. It cannot be given to others without your consent, except to the IRS, other states that guarantee the same privacy, or by court order. Your name, address, and Social Security Number are required for identification. Information about your allowances is required to determine your correct tax. We ask for your phone number so we can call if we have a question.

Questions?

- Website: www.revenue.state.mn.us
- Email: withholding.tax@state.mn.us
- Phone: 651-282-9999 or 1-800-657-3594 (toll-free)

Employer instructions are on the next page.

Form W-4MN Employer Instructions

Form W-4MN Requirement

Federal Form W-4 will not determine withholding allowances used to determine the amount of Minnesota withholding. Employees completing a 2024 Form W-4 will need to complete 2024 Form W-4MN to determine the appropriate amount of Minnesota withholding.

Lock-In Letters

IRS Letter 2800C tells you when the IRS believes your employee may have filed an incorrect federal Form W-4. If you receive this letter, you must provide the Minnesota Department of Revenue with a copy of the employee's Form W-4MN. We will verify the number of allowances that the employee may claim for Minnesota purposes. Continue using the Form W-4MN you were using at the time you received Letter 2800C from the IRS, until we notify you to change the amount of allowances on the employee's Form W-4MN. If the employee has not completed a Form W-4MN, have them complete the form and use the allowances calculated on that form until notified by the department.

Use the amount on line 1 of page 1 for calculating the withholding tax for your employees.

When does an employee complete Form W-4MN?

Employees complete Form W-4MN no later than when they begin employment or when their personal or financial situation changes.

How should I determine Minnesota withholding for an employee that does not complete Form W-4MN?

If an employee does not complete Form W-4MN and they have a federal Form W-4 (from 2019 or prior years) on file, use the allowances on their federal Form W-4. Otherwise, withhold Minnesota tax as if the employee is single with zero withholding allowances.

What if my employee claims to be exempt from Minnesota withholding?

If your employee claims exempt from Minnesota withholding, they must complete Section 2 of Form W-4MN. They must provide you with a new Form W-4MN by February 15 of each year. If you are paying an employee for wages that are exempt from withholding, such as Medicaid Waiver Payments or wages to H-2A visa workers, do not send us Form W-4MN.

When do I need to submit copies of a Form W-4MN to the department?

You must send copies of Form W-4MN to us if any of these apply:

- The employee claims more than 10 Minnesota withholding allowances
- The employee checked box A or B under Section 2, and you reasonably expect the employee's wages to exceed $200 per week
- You believe the employee is not entitled to the number of allowances claimed

You do not need to submit Form W-4MN to us if the employee is asking to have additional Minnesota withholding deducted from their pay.

We may assess a $50 penalty for each Form W-4MN you do not file with us when required.

Mail Forms W-4MN to:

Minnesota Department of Revenue
Mail Station 6501
600 N. Robert St.
St. Paul, MN 55146-6501

What if my employee is a resident of a state that has a reciprocity agreement with Minnesota?

Your employee must complete Form MWR, Reciprocity Exemption/Affidavit of Residency if both of these apply:

- They are a resident of North Dakota or Michigan, and
- They do not want you to withhold Minnesota tax from their wages

Your employee must complete a Form MWR by February 28 of each year, or within 30 days after they begin working or change their permanent residence. See Withholding Fact Sheet 20, *Reciprocity - Employee Withholding*, for more information.

What is an invalid Form W-4MN?

A Form W-4MN is considered invalid if any of these apply:

- There is any unauthorized change or addition to the form, including any change to the language certifying the form is correct
- The employee indicates in any way the form is false by the date they provide you with the form
- The form is incomplete or lacks the necessary signatures
- Both Section 1 and Section 2 were completed
- The employer information is incomplete

What if I receive an invalid form?

Do not use the invalid form to calculate Minnesota income tax withholding. Have the employee complete and submit a new Form W-4MN. If the employee does not give you a valid form, and you have an earlier Form W-4MN from them, use the earlier form to calculate their withholding.

If a valid Form W-4MN is not completed by the employee, withhold taxes as if the employee is single and claiming zero withholding allowances.

What if my employee is a nonresident alien of the United States?

If the wages to this employee are subject to income tax withholding, you will use Table 1 and the procedure under **Withholding Adjustment for Nonresident Alien Employees** in IRS Publication 15-T to determine the correct Minnesota withholding tax. Do not use this procedure for nonresident alien students from India and business apprentices from India. Also do not use this procedure for certain nonresident aliens who are residents of South Korea. See IRS Notice 1392 for special instructions and withholding exceptions.

St. Paul Electrical Workers Health Plan

1330 Conway Street • Suite 130
St. Paul, Minnesota 55106
(651) 776-4239

AUTHORIZATION TO RELEASE

PROTECTED HEALTH INFORMATION

I, ______________________________________, hereby give permission to release information regarding my health status, including protected health information, to St Paul Electrical Workers Health Plan for purposes of clarification regarding my ability to accept employment.

____

Participant Signature   Social Security #   Date

I understand that I have the right to revoke this authorization at any time. If I choose to revoke this consent, I must submit a signed written statement.

Please feel free to Fax # 651-776-9973 or Email spewbenefits@wilson-mcshane.com

Authorization to Disclose Medical Information

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service that has information about my health to disclose any and all of this information to GENEX Services, Inc. and its duly authorized representatives ("GENEX"). Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand any information GENEX obtains pursuant to this authorization will be used for case management (medical and/or vocational), peer review, utilization review, independent medical exams, and/or medical bill review. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for one (1) year from the date below. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent GENEX has relied on the authorization prior to notice of revocation. I understand if I revoke, alter, or do not sign this authorization, GENEX may not be able to provide the services described above. I may revoke this authorization by sending written notice to the address above.

___________________________________ __________________________

(Signature of Employee/Claimant/Patient) (Date Signed)

___________________________________ ___________________________

(Name – Please Print) (Social Security Number)

I, ______________________________, signed on behalf of the employee,/ claimant/.patient as _______________________________ (indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

ST. PAUL ELECTRICAL WORKERS HEALTH PLAN
1330 Conway Street • Suite 130
St. Paul, Minnesota 55106
(651) 776-4239

ACCIDENT CLAIM FORM

THIS FORM MUST BE COMPLETED WHETHER INJURY WAS DUE TO AN ACCIDENT OR NOT.

PLEASE BE SURE TO INCLUDE ALL INFORMATION REQUESTED. MISSING INFORMATION WILL DELAY PROCESSING AND POSSIBLY CAUSE DENIAL OF YOUR CLAIM

Please complete this form regarding: ____

PARTICIPANT INFORMATION:

Participant's Name: ________________________________ Social Security #:XXX-XX-__________

Is Illness or Injury related to participant's employment? Yes __________ No ____________

Date of Occurrence: ____

Give details of how and where accident occurred, i.e. at work, auto accident, or another party's home etc.

____
____
____
____
____

Is illness/accident covered by:

No Fault Auto Insurance?	Yes: _______	No: _______
Worker's Compensation Insurance?	Yes: _______	No: _______
Other Business or Private Party's Liability Insurance?	Yes: _______	No: _______
Homeowner's Insurance?	Yes: _______	No: _______

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to myself which may have a bearing on the benefits under this or any other plan providing benefits or services; and **I HEREBY ACKNOWLEDGE THAT FAILURE TO PROVIDE TRUE, CORRECT, AND COMPLETE INFORMATION WILL RESULT IN LOSS OF BENEFITS.**

Signature of Participant: ____________________________________ Date: _______________

Please feel free to Fax # 651-776-9973 or Email spewbenefits@wilson-mcshane.com

ST. PAUL ELECTRICAL WORKERS HEALTH PLAN
1330 Conway Street • Suite 130
St. Paul, Minnesota 55106
(651) 776-4239

SUBROGATION/REIMBURSEMENT/LIEN AGREEMENT
****This form is only needed if related to Work, Auto or Third Party Injury****

This Agreement is entered into this _____ day of ____________, 20_____ by and between the St. Paul Electrical Construction Medical Reimbursement Plan (the "Plan") and ______________________________residing at ____, (hereinafter referred to as "Participant") who is eligible to receive benefits under the Plan.

RECITALS

A. Participants are entitled to receive benefits from the Plan for medical expenses incurred which have not been reimbursed by other sources, provided that such expenses come within the coverage limitations set forth in the Plan of Benefits and the Summary Plan Description (hereinafter the "Plan") of the Plan.

B. Unless approved by the Trustees, Participants are not entitled to receive benefits from the Plan for medical expenses for which a third party is liable, even if such expenses have not and may never be paid by the third party.

C. The Plan has retained a subrogation right, which includes a right to impose a lien, and/or the right to seek reimbursement of amounts paid to participants (which include attorneys' fees and costs that the Plan incurs in enforcing subrogation rights) which the Participant, or its legal representative, subsequently recovers from an insurer, defendant or other source. Specifically, the Plan will pay benefits pursuant to the Plan of Benefits, but is entitled to obtain a lien or to receive from the Participant or Participant's legal representative, reimbursement of benefits previously paid to the extent the Participant is reimbursed under any liability, casualty insurance or self-insurance program or from any other source. In addition, the Participant is required by the Plan to sign such subrogation forms as the Plan may require to ensure that the Plan will receive reimbursement pursuant to its subrogation policy. All terms and conditions of the Summary Plan Description and Agreement and Declaration of Trust for the Plan are hereby incorporated and made part of this Agreement, including but not limited to those provisions setting forth the Plan's priority in subrogation.

D. For purposes of this Agreement, the term "Participant" means the individual who is entitled to benefits under the terms of the Plan. This term includes the Eligible Employee (on whose behalf contributions are made to the Plan), and any dependent or dependents or domestic partner of the Eligible Employee who are entitled to benefits under the plan of benefits provided by this Plan. When the Participant is someone other than the Eligible Employee, the name of the Eligible Employee shall be set forth at the end of this Agreement. If the Participant is a dependent of an Eligible Employee who is a minor, then the Eligible Employee shall be required to sign this Agreement on behalf of such minor.

E. The Participant, under the terms of the Plan, is not entitled to reimbursement by the Plan of expenses incurred as a result of an illness or injury which is work-related or for which coverage may be obtained through Workers' Compensation laws of the State of Minnesota or any other state.

F. The Participant has filed a claim for reimbursement of expenses incurred with the Plan Administrator of this Plan and, in addition, may be entitled to recover such expenses from another source or sources.

NOW, THEREFORE, the parties hereto agree as follows:

1. The Plan agrees to reimburse Participant according to the Plan of Benefits currently in effect, for medical expenses, disability benefits and benefits for time away from work, even though Participant may recover such expenses from another source.

2. Participant agrees to provide a lien and reimburse the Plan for all payments the Plan has made to or on behalf of Participant for medical benefits, disability benefits and/or the employers' and employees' share of social security taxes (including any attorneys' fees and costs incurred by the Plan in enforcing its subrogation rights) if Participant has recovered any judgment, recovery, payment or settlement from any source whatsoever with respect to the injury or illness which resulted in a claim for benefits being paid by the Plan to Participant or Participant's dependent or domestic partner (collectively the "Participant"). Such reimbursement by the Participant shall not exceed the amount that the Participant has received. The Plan shall have a lien and shall be reimbursed to the extent of any payments made by the Plan to or on behalf of a Participant. If any balance remains from such recovery, it shall be applied to reimburse the Participant.

3. Participant agrees to reimburse the Plan for such benefits paid by the Plan (including any attorneys' fees and costs incurred by the plan in enforcing its subrogation rights) regardless of whether or not the recovery made by the Participant is for the purpose of compensating Participant for medical expenses, lost wages, personal injury and without regard to whether the recovery is specifically designated as a recovery for certain damages or expenses. Unless otherwise agreed to by a majority of the Trustees, there shall be no reduction in the amount of reimbursement paid by the Participant to the Plan for attorneys' fees incurred or paid by the Participant in connection with said claim.

4. Should the Participant choose not to pursue any valid claims against any third party that may have caused the illness or injury for which benefits had been paid by this Plan, the Plan shall be subrogated to all rights of the Participant and the Plan may, but is not required to pursue, on behalf of the Participant, any such claims. If the Plan chooses to pursue its subrogation rights, the Participant shall not be liable for any fees or expenses that may be incurred by the Plan in pursuing such claims.

5. Participant shall notify the Plan whenever the Participant has commenced litigation, or any administrative proceeding or otherwise made a claim in connection with the illness or injury which is the subject of this Agreement, giving the Plan the names of the parties to the proceeding, and the venue for such proceeding. This is a continuing obligation and the Participant shall notify the Plan at the time this Agreement is signed of any such proceedings, and Participant shall have a continuing obligation to notify the Plan at any time that such proceedings are commenced or claims are made.

6. The Participant agrees that Participant shall notify the Plan of any attorney that the Participant has engaged to represent the Participant (or Participant's beneficiary) in any such proceeding. Further, the Participant shall notify the Plan of the discharge of such attorney and the further employment of any successor attorney. In addition, if the Participant (or Participant's beneficiary) has an attorney at the time that this document is signed, the attorney shall sign this Agreement evidencing the attorney's agreement to honor the terms of this Agreement on behalf of the Participant. Should the Participant not have an attorney at the time this Agreement is signed, but subsequently retains an attorney, such attorney at that time shall be

required to sign this Agreement. The Participant agrees to notify the attorney at the time the attorney is retained by the Participant of this specific requirement.

7. If the Participant or the attorney or other legal representative for the Participant receives any monies from any third party intended to compensate the Participant for the illness or injury for which benefits were paid by this Plan on behalf of the Participant, the Participant or the Participant's attorney or legal representative shall hold that portion of the proceeds representing the amounts paid out by this Plan in Trust for the benefit of this Plan, and shall treat such proceeds as Plan assets to be paid over to the Plan. Plan shall have a lien on such assets until the funds held in trust are paid over to the Plan.

8. If the Participant, his agents, representatives or attorneys, receives payments which were required to be paid over to the Plan pursuant to the Plan's subrogation/reimbursement/lien rights, but which payments have not bee made to the Plan, the Plan has the right to recover those amounts by deducting or offsetting those amounts from the Participant's future benefit payments from the Plan.

Dated this _______ day of ____________________, 20___.

____
Participant

____
Eligible Employee

IF THE DEPENDENT IS A MINOR, THE ELIGIBLE EMPLOYEE SHALL ALSO SIGN ON BEHALF OF THE MINOR DEPENDENT:

____
Eligible Employee on Behalf of Minor Dependent

STATE OF MINNESOTA)
) ss.
COUNTY OF _______)

Subscribed and sworn to before me by ______________________ and __________________this _____ day of ____________________, 20___.

____
Notary Public

YOU ARE NOT REQUIRED TO HAVE AN ATTORNEY, BUT IF YOU DO, THE ATTORNEY MUST SIGN BELOW, ACKNOWLEDGING LEGAL REPRESENTATION AND COMPLIANCE WITH THE TERMS OF THIS AGREEMENT.

Date:______________________________ By____
Attorney for Participant

Address

____

____

ST. PAUL ELECTRICAL CONSTRUCTION MEDICAL REIMBURSEMENT PLAN

Date:____________________ By:____
Marty Lasley
Its: Administrator

SUBROGATION AND REIMBURSEMENT AGREEMENT

I acknowledge receipt of a copy of the Subrogation, Repayment and Equitable Lien provisions contained in the St. Paul Electrical Workers Health Plan's ("Plan") Summary Plan Description and Plan Document, which are incorporated herein by reference. I have reviewed these provisions and understand that I, my dependents, heirs, guardians, executors, trustees, attorneys, representatives, assignees, or anyone acting on my behalf are bound by them. Additionally, in consideration for payment by the Plan relating to any condition for which a third party may be liable or required to make payment to me and in accordance with the terms of the Plan, I acknowledge and agree as follows:

1. I may be entitled to benefits from the Plan as a Participant or Dependent as those terms are defined by the Plan.

2. The Plan's right of reimbursement and equitable lien applies to any payment received by me from any person, entity, insurer, plan, or any other source regardless of whether I have the right, legal or otherwise to this payment or to recover the any amounts paid by the Plan.

3. I will do whatever is needed to secure the Plan's subrogation and reimbursement rights and I will do nothing to prejudice these rights.

4. I will promptly inform the Plan of any potential or actual claims, actions, lawsuits, or demands being made against any third party that may impact the Plan's subrogation and reimbursement rights before any settlements or resolutions and I will provide the Plan with the identity of all potential defendants, their addresses, insurers, adjusters, and claim numbers as well as accident reports and any other information requested by the Plan.

5. I will inform any attorney or legal representative I engage of Plan's Subrogation, Repayment and Equitable Lien provisions and of this Agreement and I will provide my attorney or legal representative's contact information to the Plan.

6. The Plan has a constructive trust and/or equitable lien on any money or payment I receive or is received on my behalf from a third-party.

7. I will hold, or I will direct my attorney or legal representative to hold, any money I receive or is received on my behalf from a third-party in trust (up to the amount paid by the Plan) for the benefit of the Plan until the Plan's subrogation and reimbursement claims are satisfied or resolved.

8. I understand that any money I receive or is received on my behalf from a third-party in trust (up to the amount paid by the Plan) will be deemed to be plan assets to be paid over to the Plan.

9. The Plan will be reimbursed first to the full extent of its subrogation and reimbursement rights out of any money I receive or is received on my behalf from a third party even if this means I do not recover all my damages.

10. The Plan will not be responsible for any attorney's fees or costs incurred by me unless the Plan agree in writing to pay all or some portion of attorney's fees or costs.

11. In the event I fail to comply with the terms of the Plan's Subrogation, Repayment and Equitable Lien provisions and this Agreement, I understand that the amounts paid by the Plan will be considered an "Overpayment," which the Plan has a right to recover by deducting from my or my dependents future benefits.

Date: ________________

____
Signature of Claimant or Claimant's Parent, Guardian, or Legal Representative

____
Printed Name of Claimant

ATTORNEY ACKNOWLEDGMENT

I have reviewed this Subrogation and Reimbursement Agreement and the Plan's Subrogation, Repayment and Equitable Lien provisions and I will comply with this Agreement. Further, I acknowledge that, if I receive any money on behalf of my client from a third party, the Plan has a constructive trust and/or equitable lien on such monies to the extent of the payments by the Plan. Finally, I acknowledge that it is my professional duty to (1) notify the Plan and/or the Plan's counsel promptly of the existence and terms of any settlement or judgment; and (2) to hold any money that come into my or my law firm's possession in which the Plan may have an interest in my trust account pending resolution of the Plan's subrogation and reimbursement claims.

____
Signature of Attorney for Claimant

____
Printed Name of Attorney

____
Attorney's Address

____
Attorney's Telephone