DISTRICT ENROLLMENT FORM

Employee Name - First	Middle	Last

Employee Number	Effective Date	District

Address	City	State	Zip	Home Phone No.

Emergency Contact	Contact Phone No.

Social Security No.

Federal Withholding Status (attach W-4)

● **Married** ● **Single** ● **Married @ Single Rate**

Federal Withholding Exemption(s)

Additional Withholding per Pay Period

Wage Rate Per

● **Hour** ● **Meeting**

● **Month**

Position

● **Non-Union** ● **Union** ● **Elected**

Health & Welfare Benefits*

Type of Benefit	Code	Type of Benefit	Code
Medical		Other:	
Dental			
Vision		Retirement	
Life			
Life Dependant			

Home Fund

Home Cost Center/Department

Date Started

Date of Birth

Gender ● **Female** ● **Male**

Job Title

Work Site

Supervisor

Employment Security ● **Covered (001)** ● **Not Covered (007)**

Social Security ● **Covered** ● **Not Covered**

Deductions*

	Amount Deducted		Effective Date
Dues: ☐ **Initiation**		/month	
☐ **Monthly**		/month	
Deferred Compensation		/month	
Financial Institution		/month	
United Way		/month	
Other:		/month	

**Attach Appropriate Forms*

Workers Comp. Codes:

● **1501 Cemeteries** ● **5306 Clerical** ● **1507 Water** ● **Other:**

Comments:

Commissioner	Date	Prepared By	Date

Commissioner	Date	Input By	Date