Klawock City School District

P.O. Box 9 Klawock, Alaska 99925 907-755-2220 Fax: 907-755-2913

Jim Holien
Superintendent

Kelli Larson
K -12 Principal

403(b) UNIVERSAL AVAILABILITY NOTICE

The Opportunity.

You have the opportunity to save for retirement by participating in your Employer's 403(b) retirement plan. If there are any questions, you may contact the Plan's administrator, The OMNI Group at 877-544-6664.

We recommend that all employees view a brief, 3-minute video presentation called, '403(b). Why me?' explaining a 403(b) plan, and how to contribute. The video can be viewed on OMNI's website at www.omni403b.com.

How Can I Participate?

You can participate in the Plan with pre-tax contributions by submitting a Salary Reduction Agreement ("SRA") online via OMNI's website or by submitting a completed SRA form, found on the same website, to OMNI either by facsimile to (585) 672-6194 or by mail to 1099 Jay St., Bldg F, Rochester, NY, 14611. Additionally, prior to contributing you must open an account with an investment provider participating in the Plan. A list of the Plan's participating investment providers may be viewed on OMNI's website after submitting your Employer's name and state.

How Much Can I Contribute Annually?

You may contribute up to $19,500 in 2020; this amount is subject to change annually. If you have at least 15 years of service with your employer or you are at least 50 years old, you may be entitled to make additional contributions. For appropriate limits for your particular circumstances, please contact OMNI's Customer Care Center at 877-544-6664.

What If I Already Have An Account?

If you are already contributing to the Plan, and you want to change your contribution amount or investment provider, simply complete and submit a new SRA. See directions above for on-line and paper submission options.

What If I Do Not Want To Contribute?

If you do not want to take advantage of this program, simply check the option "I have chosen NOT to enroll in a 403 (b) plan" on the Klawock City School District's 403 (b) Acknowledgement form. See directions above for on-line and paper submission options.

How can I get more information?

You can access further information at www.omni403b.com.

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KLAWOCK CITY SCHOOL DISTRICT
403 (b) Acknowledgement

I understand that I, as an eligible employee of the Klawock City School District, have the opportunity to enroll in a 403(b) retirement plan.

At this time ( ) I have enrolled in a 403 (b) plan
( ) I have chosen NOT to enroll in a 403 (b) plan

______________________________ ______________
SIGNATURE: DATED:

____
PRINTED NAME

POST HIRE QUESTIONNAIRE FOR SECOND INJURY FUND QUALIFICATION

The purpose of this questionnaire is to preserve the Employer's right to obtain Second Injury Fund reimbursement if you suffer a work-related injury while employment. If the resulting disability is greater due to aggravation of a pre-existing condition, or because the injury combines with the pre-existing condition, the Employer may be able to obtain reimbursement from the Fund for some of the workers' compensation benefits paid to you. The completed questionnaire will be retained in your confidential medical file. You may update the information at any time.

Name ______________________ Social Security No. ______________________

Address ______________________ Date of Birth ______________________

______________________ Telephone ______________________

Have you ever had, or do you now have, any of the following conditions? *Note: this list is derived from Alaska Statute 23.30.205. PLEASE COMPLETE BOTH COLUMNS.*

YES	NO	
___	___	EPILEPSY
___	___	MUSCULAR DYSTROPHY (any form)
___	___	PARKINSON'S DISEASE
___	___	POLIOMYELITIS residuals
___	___	CEREBRAL PALSY
___	___	CEREBRAL VASCULAR ACCIDENT(Stroke)
___	___	MULTIPLE SCLEROSIS
___	___	CHRONIC OSTEOMYELITIS
___	___	RUPTURED (HERNIATED) INTERVETEBRAL DISC (SPINAL DISK OR H.N.P.)
___	___	ANKYLOSIS OF JOINTS (Fused joints)
___	___	OSTEOPOROSIS
___	___	ARTHRITIS of any kind
___	___	SPONDYLOLISTHESIS
___	___	HEMOPHILIA

YES	NO	
___	___	DIABETES
___	___	HYPERINSULINISM
___	___	TUBERCULOSIS
___	___	LOSS OF SIGHT one or two eyes
___	___	VISION LOSS greater than 75% bilaterally, uncorrected
___	___	VARICOSE VEINS
___	___	THROMBPHLEBITIS
___	___	ARTERIOSCLEROSIS
___	___	CARDIAC DISEASE of any kind
___	___	SILICOSIS
___	___	COMPRESSED AIR SEQUELAE
___	___	HEAVY METAL POISONING
___	___	IONIZING RADIATION INJURY
___	___	AMPUTATION foot, leg, arm,hand

Have you ever had, or do you now have any condition, disease or injury which resulted in 200 weeks or more of inability to work? *The 200 weeks need not be continuous. If your answer is yes, please briefly describe the condition or injury.*______________________

Have you ever had a permanent impairment rating of 35% of the whole person or greater? *If your answer is yes, please state the condition or injury which led to the rating.*______________________

READ CAREFULLY, SIGN AND DATE:

I understand that the Employer is relying on me to be honest in my answers, and that concealment of a qualifying condition may result in the Employer having to pay more for workers' compensation benefits than it would if I had disclosed a qualifying condition. I have answered the above questions to the best of my knowledge. I understand that this information will be kept in my confidential medical file and will be used for workers' compensation purposes only.

Signed ______________________ Dated ______________________