ENCLOSED ARE FORMS FOR MARRIAGE OR DIVORCE (ADDING/REMOVING DEPENDENTS, CHANGING ADDRESS, BENIFICIARIES, TAX RETURNS, ETC)

~~return forms to Shelly Och, Coordinator of Employee Benefits & Payroll; soch@k12.wv.us; 304-843-4400, x341

FOR WV PEIA HEALTH INSURANCE, CHANGES MUST BE MADE WITH 60 DAYS OF THE EVENT:

1. COMPLETE AND RETURN WITH REQUIRED DOCUMENTATION

   OR

2. Log on to the WV PEIA website, select "Manage My Benefits"
   Create your Account (if have not already created an account)
   Make desired changes
   Upload documentation
   REMEMBER, IF ENROLLING IN A PEIA PPB PLAN, LOOK CLOSELY AT THE HEALTHY TOMORROWS PROGRAM REQUIREMENTS IN THE FRONT OF THE SHOPPERS GUIDE.

STATUS CHANGE EVENT	**DOCUMENTATION REQUIRED**
Divorce	First and Last page of the signed divorce decree.
Marriage	Copy of valid marriage license/certificate.
Birth of Child	Copy of child's birth certificate.
Adoption	Copy of adoption papers
Adding dependent coverage	Copy of child's birth certificate
Open enrollment for spouse	Copy of printed material showing enrollment dates w/ employer name
Death of spouse/dependent	Copy of death certificate
Beginning of spouse employment	Letter from employer stating hire date, date of insurance, coverage, dependents covered
End of spouse employment	Letter from employer stating term date, date of lost coverage, dependents covered
Change in health coverage due to spouse's employment	Letter from insurance carrier indicating the change in coverage, the effective date of the change, dependents covered
Unpaid leave of absence	A letter from your, your spouse's, or dependent's personnel office stating date went or returned from unpaid leave
Change from FT to PT	A letter from your, your spouse's, or dependent's employer stating the previous hrs and new hrs worked and effective dates.

State of West Virginia • Public Employees Insurance Agency
Change-In-Status Form

Change in Status

Complete this form to change the status of your coverage. Complete all sections as appropriate except the Employer Information on page 2 and return the form to your benefit coordinator.

Name (Last)	(First)	(MI)	(Generation: Jr., Sr., etc.)	Social Security Number
Street Address Check if New Address ☐		County of Residence		Home Phone ( )
City	State	Zip	Job Title	Work Phone ( )

Do you participate in the IRS Section 125 Premium Conversion Plan sponsored by PEIA, if available? YES ☐ NO ☑

CHANGE TYPE Please indicate the status change you are making:

- 001 ☐ Name Change: Policyholder ☐ Dependent ☐ (Last)________ (First)________ (MI)____
- 002 ☐ Transfer employee's premium billing from employer account # ______ to account # ______ within the same agency
- 003 ☐ Add Dependents to: (Mark your choice) ☐ Health ☐ Dependent Optional Life Insurance (check one) ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 ☐ Plan 4 ☐ Plan 5
  (Complete dependent information below. If not in the initial enrollment period, Evidence of Insurability is required for life insurance.)
- 004 ☐ Remove Dependents from: (Mark your choice and complete dependent information below) ☐ Health ☐ Dependent Optional Life Insurance
- 005 ☐ Change in health coverage: From: (Plan Name)________ To: (Plan Name) ________
- 006 ☐ Add Health Coverage: ☐ PEIA PPB Plan A ☐ PEIA PPB Plan B ☐ PEIA PPB Plan C ☐ PEIA PPB Plan D ☐ Health Plan HMO Plan A ☐ Health Plan HMO Plan B ☐ Health Plan HMO Plan C
- 007 ☐ Drop Health Coverage. Keep life insurance ONLY. This terminates health coverage for policyholder and all dependents.
- 008 ☐ Tobacco Status Change.
- 009 ☐ Advance Directive/Living Will Affidavit Change.

Dependent Name (Last, First, MI, Generation)	Address (if different from above)	Relationship (Circle One)	Sex (Circle One)	Birth Date (mm/dd/yyyy)	Social Security Number
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		
		SP CH	M F		

Status Change Reason. Policyholder must provide documentation for every type of status change. See attached memo for details.

1	Marriage	5	Death of spouse or dependent	9	Change from full-time to part-time employment or vice versa for employee, spouse, or dependent
2	Divorce	6	Beginning or end of spouse's or dependent's employment	10	Open Enrollment
3	Birth of Child	7	Significant change in health coverage due to spouse's or dependent's employment	11	Other (please specify): ________
4	Adoption	8	Unpaid leave of absence by employee, spouse, or dependent		

I certify that on ____/____/____(date of event) I incurred the status change marked above, and I, therefore, wish to change my plan benefits as indicated. I understand that the change requested must be consistent with the event. I further understand that I am required to provide documentation of this event to the WV Public Employees Insurance Agency.

This form is continued on page 2. You must complete and return both pages of the form for it to be valid. Please continue.

Change in Status Form
Page 2

Policyholder's Last Name: ______________________ Last four digits of SSN: ____________

COBRA

Under Federal COBRA law, PEIA must offer continued coverage to qualified policyholders or dependents under certain circumstances. If you qualify, you will be sent notification with the necessary applications by HealthSmart Benefit Solutions, who administers COBRA for the PEIA. You will have a limited amount of time to elect continuation of coverage. If dependent's address is different than the policyholder's address, please provide the dependent's address here:

Dependent Name: ______________________

Street Address: ______________________

City, State, Zip ______________________

Premium Discount Affidavits

Tobacco Affidavit: Mark which members of the family (if any) use tobacco and sign the acceptance box below. If no one enrolled on your coverage uses tobacco, you will receive a premium discount on your health coverage and/or optional life insurance. I acknowledge by signing the Acceptance box below that WVPEIA or its agents have access to my medical records to check my tobacco use status.

Who uses tobacco: ☐ Policyholder ☐ Dependent (spouse and/or children) ☐ No Tobacco Users within the last six (6) months

Living Will Affidavit: PEIA offers a premium discount to health policyholders who have executed a Living Will/Advance Directive. If you have a valid living will, please check the box beside the statement below and sign the form in the Acceptance box below.

☐ By checking this box, I acknowledge that I have executed a valid Living Will or advance directive, and that I have discussed its contents with the appropriate parties, including my family and my health care provider.

Acceptance

I hereby accept the changes to my group coverage I have indicated above. I understand that the PEIA may change the types or levels of benefits or the amount of contribution, and that the changes I have made may affect my contributions. I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted. I hereby consent, for myself and my covered dependents, to the release to PEIA and to the plan I have selected, of all medical and prescription drug information needed to process claims, determine coverage, review utilization, investigate complaints, assess quality of care, evaluate plan performance or any other process involved in my treatment, payment of claims or health care operations.

Employee's Signature: Date:

Employer Information -- TO BE COMPLETED BY AGENCY BENEFIT COORDINATOR

Account Number

8 0 0 5 1 0 0 0 5

Agency Name (optional): Marshall County Schools

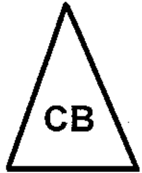
Effective Date of Status Change __ __ / __ __ / __ __ __ __ Index Code __ __

I hereby certify that, to the best of my knowledge, the information contained herein is accurate. I further certify that the applicant meets the minimum eligibility requirements for the Public Employees Insurance Plan.

Authorized Signature: Shelly M Wel Date:

Please submit only the original to PEIA

State of West Virginia
Public Employees Insurance Agency
Basic and/or Optional Life Insurance Change of Beneficiary Form



Complete this form to update or change the distribution of your life insurance benefits.
Complete the Policyholder section of the form and return the completed form to PEIA.

POLICYHOLDER

Name (Last)	(First)	(MI)	(Generation Jr., Sr., etc.)	Social Security Number

Sex (Check One) ☐ Male ☐ Female	Date of Birth (mm/dd/yyyy)	Work Phone ( )
Street Address City State Zip		**Home Phone** ( )

Please choose one of the following

- ☐ **Please change the beneficiary(s) of my Basic Life Insurance. Complete Section A below.**
- ☐ **Please change the beneficiary(s) of my Optional Life Insurance. Complete Section B below.**
- ☐ **Please change the beneficiary(s) of both my Basic and Optional Life Insurance. Complete Section A and Section B below.**

If more than one beneficiary is named, you may divide the death benefit by noting what percentage is to be paid to each beneficiary in the "Distribution %" box. If no percentage is noted the death benefit will be paid in equal shares to the named beneficiaries who survive the employee. If unequal percentages are assigned to the beneficiaries, the share of any beneficiary who predeceases the employee will be distributed equally among all surviving named beneficiaries. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

SECTION A – BASIC LIFE INSURANCE CHANGE OF BENEFICIARY

Please designate the beneficiary(s) of your basic life insurance coverage below. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not Mrs. John Doe" or "Mrs. J. A. Doe".

Beneficiary Name (Last, First, MI, Generation)	Beneficiary Address (Street, City, State, Zip)	Telephone #	Relationship to the Insured	Distribution %

SECTION B - OPTIONAL LIFE INSURANCE CHANGE OF BENEFICIARY

Please designate the beneficiary(s) of your optional life insurance coverage below. The name of the beneficiary should be fully spelled out, and written "Jane B. Doe," not Mrs. John Doe" or "Mrs. J. A. Doe".

Beneficiary Name (Last, First, MI, Generation)	Beneficiary Address (Street, City, State, Zip)	Telephone #	Relationship to the Insured	Distribution %

I wish to make the changes marked above. I understand that I may, at a future date, choose to change the above beneficiary(s) in accordance with policy provisions.

Policyholder's Signature ______________________ **Date:** __________

Witness' Signature ______________________ **Date:** __________
(Must be a person other than a beneficiary.)

Distribution: Mail original to:
PEIA
601 57th Street, SE, Suite 2
Charleston, WV 25304-2345

Please keep a copy for your records.

Revised December 2010

PEIA Change In Address Form

Revised Nov. 1, 2011
CA-201101

Please mail the completed form to: **PEIA, 601 57th St. SE, Suite 2, Charleston, WV 25304-2345**

First Name: ____ Middle Name: ____

Last Name: ____ Generation (Jr., Sr., III, etc) Leave blank if none. ____

New Address: ____

____

City: ____ State: ____ Zip Code: ____ - ____

County ____ Country: ☐ USA ☐ Other (specify): ____

SSN: ____ Home Phone (____) ____ - ____ Work Phone (____) ____ - ____

Effective Date of New Address (mm/dd/yyyy) ____ / ____ / ____

E-mail: ____

Would you like to make e-mail your preferred method of communication from PEIA? If yes, you must keep your e-mail address up to date with PEIA to receive plan communications. If no, you will continue to receive US mail from PEIA. ☐ Yes ☐ No

PEIA is required to collect a physical address in addition to a mailing address. The physical address **CANNOT** be a post office box. If your physical address is different than your mailing address, please complete the section below. PEIA will continue to mail to your mailing address, and will simply keep a record of your physical address.

Physical Address: ____

____

City: ____ State: ____ Zip Code: ____ - ____

County: ____ Country: ☐ USA ☐ Other (specify): ____

I certify that the above information is true and correct and understand that providing false information on this form is illegal and that those who provide false information may be prosecuted.

Policyholder Signature: ____ Date: ____

State of West Virginia
Consolidated Public Retirement Board
Internet Form (Signature in Blue Ink Only)
4101 MacCorkle Avenue SE, Charleston, West Virginia 25304-1636
Telephone: 304-558-3570 or 800-654-4406 Fax: 304-558-1394

PRE-RETIREMENT BENEFICIARY
TEACHERS DEFINED BENEFIT RETIREMENT SYSTEM

(In Blue Ink Only)

SS# ______________________ EMPLOYER: Marshall County Schools

DATE OF BIRTH: ____________________ PHONE: ______________________

I______________________________, do hereby direct that in the event of my death before my annuity starting date, the Teachers' Defined Benefit Retirement System be authorized and directed to pay the full amount of my accumulated contributions, plus any interest, to the person(s) designated below, as my named beneficiary(ies).

I further understand that if I am at least fifty (50) years old and have at least twenty-five (25) years of total service at the time of my death, my surviving spouse will become entitled to a monthly annuity **only** if my spouse is designated as my sole primary refund beneficiary (WV Code §18-7A-23(b)(1)).

I reserve the right to change my beneficiary at any time prior to my retirement, my death or my withdrawal from membership. It is understood before such change can become effective, it must be executed on the beneficiary form approved by the West Virginia Consolidated Public Retirement Board.

Full Name of Beneficiary	Address *(Required)*	SSN	Date of Birth	Relationship	Percentage
Primary ☐ Secondary ☐					%
Primary ☐ Secondary ☐					%
Primary ☐ Secondary ☐					%
Primary ☐ Secondary ☐					%
Primary ☐ Secondary ☐					%

Note: You may elect to name multiple primary and/or secondary beneficiaries. If you wish to do so and need more space than is provided, attach to this form a sheet of paper with your name and social security number; include all beneficiary information required above, whether the beneficiary is to be Primary or Secondary, plus the percent of the distribution each is to receive.

Once accepted by CPRB, this form supersedes any and all prior Beneficiary Designations for you under TRS.

SIGNATURE OF MEMBER: ______________________________ DATE: ______________

ADDRESS OF MEMBER: ____

SIGNATURE OF WITNESS: ______________________________ DATE: ______________

(Witness must be someone other than named beneficiary or member)

ADDRESS OF WITNESS: ____

State of West Virginia
Consolidated Public Retirement Board
Internet Form (Signature in Blue Ink Only)
4101 MacCorkle Avenue SE, Charleston, West Virginia 25304-1636
Telephone: 304-558-3570 or 800-654-4406 Fax: 304-558-1394

REQUEST FOR CHANGE OF ADDRESS
For NonRetirees only

Retirees please use form located at http://www.wvretirement.com/forms/ChangeAddress.pdf

Please select your plan:

- ☐ **Public Employees Retirement System**
- ☐ **Deputy Sheriff Retirement System**
- ☐ **State Troopers Retirement**
- ☑ **Teachers Retirement (including service personnel)**
- ☐ **Judges Retirement System**

Select all that apply: ☐ Loan ☐ Refund ☐ Other ☐ Reinstatement ☐ QDRO

Member Name: ____________________

Social Security Number: ____________________

Telephone Number: ____________________

Old Address: ____________________

____

I, ____________________, do hereby request that the Consolidated Public Retirement Board, as administrator of my state retirement plan, change my mailing address for all purposes relevant under said plan to the following:

New Address: ____________________

____

I understand that this will be the address to which all state retirement plan notices, information and correspon-dencewill be sent on my behalf unless and until I notify the Consolidated Public Retirement Board, in writing, of anysubsequent address change which should be made.

Dated: ____________________ Signed: ____________________

State of West Virginia
Consolidated Public Retirement Board
Internet Form (Signature in Blue Ink Only)
4101 MacCorkle Avenue SE, Charleston, West Virginia 25304-1636
Telephone: 304-558-3570 or 800-654-4406 Fax: 304-558-1394

CHANGE OF NAME OF MEMBER

I hereby certify that on ____________________ my name was

changed from ____________________

to ____________________*

**Please attach legal documentation supporting such change (i.e. marriage certificate, divorce decree or court order.)*

My Social Security Number is ____________________

Employer ____________________

Dated at ____________________

this ____________ day of ____________ , 20____

____________________ (Signature of Witness)

____________________ (Signature of Member)

Street ____________________

City ____________________

State ____________________

Zip Code ____________________

Phone ____________________

Email Address ____________________

NOTE: If you have not yet retired and wish to change the name of your beneficiary, it will be necessary for you to complete an updated Pre-Retirement Beneficiary Form.

CPRB Use Only

Plan: ☐ PERS ☐ TRS ☐ DSRS ☐ JRS ☐ EMSRS
☐ PLAN A ☐ PLAN B ☐ MPFRS

☐ *Active* ☐ *Retired* ☐ *Beneficiary* ☐ *Loans*

Form W-4 (2016)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2016 expires February 15, 2017. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions do not apply to supplemental wages greater than $1,000,000.

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or 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-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

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

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2016. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4.*

Personal Allowances Worksheet (Keep for your records.)

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

B Enter "1" if:
- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ____

C Enter "1" for your **spouse.** But, you may 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 number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . **D** ____

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ____

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ____
(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.
- If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child . . **G** ____

H Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ► **H** ____

For accuracy, **complete all worksheets that apply.**
- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2016

1 Your first name and middle initial	Last name	2 **Your social security number**

Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ____

6 Additional amount, if any, you want withheld from each paycheck . . . **6** $ ____

7 I claim exemption from withholding for 2016, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . ► **7** ____

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date ►**

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

WEST VIRGINIA EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE FORM WV/IT-104

Complete this form and present it to your employer to avoid any delay in adjusting the amount of state income tax to be withheld from your wages.

If you do not complete this form, the amount of tax that is now being withheld from your pay may not be sufficient to cover the total amount of tax due the state when filing your personal income tax return after the close of the year. You may be subject to a penalty on tax owed the state.

Individuals are permitted a maximum of one exemption for themselves, plus an additional exemption for their spouse and any dependent other than their spouse that they expect to claim on their tax return.

If you are married and both you and your spouse work and you file a joint income tax return, or if you are working two or more jobs, the revised withholding tables should result in a more accurate amount of tax being withheld.

If you are Single, Head of Household, or Married and your spouse does not work, and you are receiving wages from only one job, and you wish to have your tax withheld at a lower rate, you must check the box on line 5.

When requesting withholding from pension and annuity payments you must present this completed form to the payor. Enter the amount you want withheld on line 6.

If you determine the amount of tax being withheld is insufficient, you may reduce the number of exemptions you are claiming or request additional taxes be withheld from each payroll period. Enter the additional amount you want to have withheld on line 6.

------------------------------ cut here ------------------------------

WV/IT-104
Rev. 12/09

WEST VIRGINIA EMPLOYEEE'S WITHHOLDING EXEMPTION CERTIFICATE

Name____________________ Social Security Number____________________

Address____

City____________________ State__________ Zip Code__________

1. If SINGLE, and you claim an exemption, enter "1", if you do not, enter "0 .... ______
2. If MARRIED, one exemption each for husband and wife if not claimed on another certificate.
   (a) If you claim both of these exemptions, enter "2"
   (b) If you claim one of these exemptions, enter "1"
   (c) If you claim neither of these exemptions, enter "0" .... ______
3. If you claim exemptions for one or more dependents, enter the number of such exemptions. .... ______
4. Add the number of exemptions which you have claimed above and enter the total .... ☐
5. If you are Single, Head of Household, or Married and your spouse does not work, and you are receiving wages from only one job, and you wish to have your tax withheld at a lower rate, check here .... ☐
6. Additional withholding per pay period under agreement with employer, enter amount here .... $ ______

Note that special withholding allowances provided on Federal Form W-4 may not be claimed on your West Virginia Form WV/IT-104 I CERTIFY, under penalties provided by law, that the number of exemptions claimed in this certificate is not in excess of those to which I am entitled.

Date____________ Signature____________________

NONRESIDENTS-SEE REVERSE SIDE