HAWAII NATIONAL GUARD
HUMAN RESOURCES OFFICE

BULLETIN

NUMBER 20-09 1 April 2020

Remote New Employee Orientation

1. Reference.

OPM Memorandum Subject: On-boarding processes for new employees during the COVID-19 emergency.

2. Applicability. National Guard T32 dual status technicians, National Guard T5 employees

3. Background.

a. New employee is required to complete the new employee orientation to prepare them for their career as a federal technician as well as to collect pre-employment documents.

b. The Federal Government has mandated the implementation of social distancing and is requiring gatherings to be limited to no more than 10 people in order to reduce the spread of the COVID-19 virus. The Federal Government is responsible to put systems in place to keep employees safe.

4. General Guidelines.

a. New Employee Orientation will be conducted remotely via the DCS application (requires CAC). Supervisors will ensure that new employees can log in from a personal computer or make a computer available. New employees will also require a telephone to call in to the orientation. Directions to new employees will be sent via email prior to NEO with the details of their orientation to include: date/time, web address, login information, and documents required.

b. Once the orientation is complete, the supervisor will screen documents and assist the employee in submitting all documentation requiring wet signature (SF61, OF306, SF2823, SF3102, SF 144, SF1152 and I-9, when applicable) to HRO the day of the New Employee Orientation. Supervisors must conduct review of acceptable documents for the I-9. The list of document requirements are located on the HRO website (https://dod.hawaii.gov/hro/tech-tools/ → New Employee Orientation) and below in Enclosure 1. Documents need to be dated as follows: temp techs and new employees date forms the day of the NEO, conversions will date forms as of the Sunday (first day of the working pay period) before the NEO. Documents will be submitted to the following

emails: charla.l.quiambao.civ@mail.mil, leanna-marie.sanchez-abella@us.af.mil and crystal.m.fujimoto.civ@mail.mil.

c. Finance documents including: ATAAPs form, W4, HW4 and SF1199A Direct Deposit, will be submitted to the finance office. The point of contact for the Air Finance Office is MSgt Carleton Tajiri at 315-447-0272 to at carleton.tajiri@us.af.mil. The point of contact for the Army Finance Office is SFC Christopher Nakama at 808-844-6355 or at chrisopher.p.nakama.mil@mail.mil.

d. State of Hawaii, Department of Defense Identification badges are still required by HING Policy Directive 2013-1. All new employees will complete the State of Hawaii DoD ID Request Form and submit with their NEO documents along with a headshot photo. Badges will be distributed through the state messenger service. Request form is Enclosure 2 in this bulletin.

5. Any questions or concerns regarding New Employee Orientation may be directed to the Deputy HRO, Mr. John Yim at 808-672-1555 or at john.k.yim4.civ@mail.mil.

2 Encls:
1. New Employee Required Documentation List
2. HI DOD Badge Request Form

New Employee Required Documentation

Temporary	Conversions	Permanents
OF 306 Declaration for Federal Employment	OF 306 Declaration for Federal Employment	OF 306 Declaration for Federal Employment
SF 144 Statement of Prior Federal Service (orders and DD214 optional)	SF 144 Statement of Prior Federal Service (orders and DD214 optional)	SF 144 Statement of Prior Federal Service (orders and DD214 optional)
TRS FEHB Acknowledgement	TRS FEHB Acknowledgement	TRS FEHB Acknowledgement
Condition of Employment (Title 32 ONLY)	Condition of Employment (Title 32 ONLY)	Condition of Employment (Title 32 ONLY)
SF 1152 Designation of Beneficiary (Unpaid compensation)	SF 1152 Designation of Beneficiary (Unpaid compensation) optional if already in eOPF	SF 1152 Designation of Beneficiary (Unpaid compensation)
ATAAPS form (Army or Air)	**<--turn into supervisor / finance-->**	ATAAPS form (Army or Air)
W4 for that year		W4 for that year
HW4 for that year		HW4 for that year
SF 1199A Direct Deposit Sign up form		SF 1199A Direct Deposit Sign up form
Employee Educational Data		Employee Educational Data
I-9 Employment Eligibility Verification		I-9 Employment Eligibility Verification
MOU temp appointment (Dec 2014)		
Notifiction to temps: Eligibility for FEHB		
	SF 3102 Designation of Beneficiary (FERS) optional if already in eOPF	SF 3102 Designation of Beneficiary (FERS)
SF 256 Self-Identification of Disability		SF 256 Self-Identification of Disability
	SF 2823 Designation of Beneficiary (FEGLI) optional if already in eOPF	SF 2823 Designation of Beneficiary (FEGLI)
SF 181 Ethnicity and Race Identification		SF 181 Ethnicity and Race Identification

*** Temporary and permanent hires date forms as of today**

*** Conversions date forms as of their conversion date (usually start of new pay period, Sunday)**

Common Errors to Look for: ensure individuals put actual date, not birth date unless specified, Name needs to be their full legal name

Everyone

Declaration for Federal Employment*

(*This form may also be used to assess fitness for federal contract employment)

Form Approved:
OMB No. 3206-0182

GENERAL INFORMATION

1. **FULL NAME** (Provide your full name. If you have only initials in your name, provide them and indicate "Initial only". If you do not have a middle name, indicate "No Middle Name". If you are a "Jr.," "Sr.," etc. enter this under Suffix. First, Middle, Last, Suffix)

♦

2. **SOCIAL SECURITY NUMBER**

♦

3a. **PLACE OF BIRTH** (Include city and state or country)

♦

3b. **ARE YOU A U.S. CITIZEN?**

☐ YES ☐ NO (If "NO", provide country of citizenship) ♦

4. **DATE OF BIRTH** (MM / DD / YYYY)

♦

5. **OTHER NAMES EVER USED** (For example, maiden name, nickname, etc)

♦

♦

6. **PHONE NUMBERS** (Include area codes)

Day ♦

Night ♦

Selective Service Registration

If you are a male born after December 31, 1959, and are at least 18 years of age, civil service employment law (5 U.S.C. 3328) requires that you must register with the Selective Service System, unless you meet certain exemptions.

7a. Are you a male born after December 31, 1959? ☐ YES ☐ NO (If "NO", proceed to 8.)

7b. Have you registered with the Selective Service System? ☐ YES (If "YES", proceed to 8.) ☐ NO (If "NO", proceed to 7c.)

7c. If "NO," describe your reason(s) in item 16.

Military Service

8. Have you ever served in the United States military? ☐ YES (If "YES", provide information below) ☐ NO

If you answered "YES," list the branch, dates, and type of discharge for all active duty.
If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From (MM/DD/YYYY)	To (MM/DD/YYYY)	Type of Discharge

Background Information

For all questions, provide all additional requested information under item 16 or on attached sheets. The circumstances of each event you list will be considered. However, in most cases you can still be considered for Federal jobs.

For questions 9,10, and 11, your answers should include convictions resulting from a plea of *nolo contendere* (no contest), but omit (1) traffic fines of $300 or less, (2) any violation of law committed before your 16th birthday, (3) any violation of law committed before your 18th birthday if finally decided in juvenile court or under a Youth Offender law, (4) any conviction set aside under the Federal Youth Corrections Act or similar state law, and (5) any conviction for which the record was expunged under Federal or state law .

9. During the last 7 years, have you been convicted, been imprisoned, been on probation, or been on parole? (Includes felonies, firearms or explosives violations, misdemeanors, and all other offenses.) *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

10. Have you been convicted by a military court-martial in the past 7 years? *(If no military service, answer "NO.") If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the military authority or court involved.* ☐ YES ☐ NO

11. Are you currently under charges for any violation of law? *If "YES," use item 16 to provide the date, explanation of the violation, place of occurrence, and the name and address of the police department or court involved.* ☐ YES ☐ NO

12. During the last 5 years, have you been fired from any job for any reason, did you quit after being told that you would be fired, did you leave any job by mutual agreement because of specific problems, or were you debarred from Federal employment by the Office of Personnel Management or any other Federal agency? *If "YES," use item 16 to provide the date, an explanation of the problem, reason for leaving, and the employer's name and address.* ☐ YES ☐ NO

13. Are you delinquent on any Federal debt? (Includes delinquencies arising from Federal taxes, loans, overpayment of benefits, and other debts to the U.S. Government, plus defaults of Federally guaranteed or insured loans such as student and home mortgage loans.) *If "YES," use item 16 to provide the type, length, and amount of the delinquency or default, and steps that you are taking to correct the error or repay the debt.* ☐ YES ☐ NO

Everyone

Declaration for Federal Employment*

(*This form may also be used to assess fitness for federal contract employment)

Form Approved:
OMB No. 3206-0182

Additional Questions

14. Do any of your relatives work for the agency or government organization to which you are submitting this form? (Include: father, mother, husband, wife, son, daughter, brother, sister, uncle, aunt, first cousin, nephew, niece, father-in-law,mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, and half sister.) *If "YES," use item 16 to provide the relative's name,relationship, and the department, agency, or branch of the Armed Forces for which your relative works.* ☐ YES ☐ NO

15. Do you receive, or have you ever applied for, retirement pay, pension, or other retired pay based on military, Federal civilian, or District of Columbia Government service? ☐ YES ☐ NO

Continuation Space / Agency Optional Questions

16. Provide details requested in items 7 through 15 and 18c in the space below or on attached sheets. Be sure to identify attached sheets with your name, Social Security Number, and item number, and to include ZIP Codes in all addresses. If any questions are printed below, please answer as instructed *(these questions are specific to your position and your agency is authorized to ask them).*

Certifications / Additional Questions

APPLICANT: If you are applying for a position and have not yet been selected, carefully review your answers on this form and any attached sheets. When this form and all attached materials are accurate, read item 17, and complete 17a.

APPOINTEE: If you are being appointed, carefully review your answers on this form and any attached sheets, including any other application materials that your agency has attached to this form. If any information requires correction to be accurate as of the date you are signing, make changes on this form or the attachments and/or provide updated information on additional sheets, initialing and dating all changes and additions. When this form and all attached materials are accurate, read item 17, complete 17b, read 18, and answer 18a, 18b, and 18c as appropriate.

17. **I certify** that, to the best of my knowledge and belief, all of the information on and attached to this Declaration for Federal Employment, including any attached application materials, is true, correct, complete, and made in good faith **. I understand that a false or fraudulent answer to any question or item on any part of this declaration or its attachments may be grounds for not hiring me, or for firing me after I begin work, and may be punishable by fine or imprisonment. I understand** that any information I give may be investigated for purposes of determining eligibility for Federal employment as allowed by law or Presidential order. **I consent** to the release of information about my ability and fitness for Federal employment by employers, schools, law enforcement agencies, and other individuals and organizations to investigators, personnel specialists, and other authorized employees or representatives of the Federal Government. **I understand** that for financial or lending institutions, medical institutions, hospitals, health care professionals, and some other sources of information, a separate specific release may be needed, and I may be contacted for such a release at a later date.

17a. Applicant's Signature: _____ (Sign in ink) Date _____

17b. Appointee's Signature: _____ (Sign in ink) Date _____

Appointing Officer:
Enter Date of Appointment or Conversion
MM / DD / YYYY

Rehires

18. **Appointee (Only respond if you have been employed by the Federal Government before):** Your elections of life insurance during previous Federal employment may affect your eligibility for life insurance during your new appointment. These questions are asked to help your personnel office make a correct determination.

18a. When did you leave your last Federal job? DATE: MM / DD / YYYY

18b. When you worked for the Federal Government the last time, did you waive Basic Life Insurance or any type of optional life insurance? ☐ YES ☐ NO ☐ DO NOT KNOW

18c. If you answered "YES" to item 18b, did you later cancel the waiver(s)? If your answer to item 18c is "NO," use item 16 to identify the type(s) of insurance for which waivers were not canceled. ☐ YES ☐ NO ☐ DO NOT KNOW

Everyone

STATEMENT OF PRIOR FEDERAL SERVICE

To be Completed by Employee

1. Name (Last, First, Middle Initial)	2. Social Security Number	3. Date of Birth (Month, Day, Year)

4. Does the application or resume that you submitted, for the position to which you are being appointed, list all of your Federal government civilian and uniformed service, including beginning and ending dates, as well as the type of appointment and work schedule for civilian service?
☐ Yes — If "Yes", check this block and skip to Item 8. ☐ No — If "No", check this block and complete Items 5 - 9.

5. List below your prior civilian service. Include service with the DC Government on appointments made before October 1, 1987.

NAME AND LOCATION OF AGENCY	FROM			TO			TYPE OF APPOINTMENT AND WORK SCHEDULE (Full-Time, Part-Time, or Intermittent)
	Year	Month	Day	Year	Month	Day	

6. During periods of employment shown in Item 5, did you have a total of more than 6 months' absence without pay during any one calendar year?
☐ Yes — If "Yes", list the following information. ☐ No — If "No", go to Item 7.

TYPE OF ABSENCE, IF KNOWN (LWOP, Furlough, Suspension, AWOL, or Placement in Nonpay Status)	FROM			TO			TOTAL		
	Year	Month	Day	Year	Month	Day	YEARS	MONTHS	DAYS

7. List all uniformed service below. List active service in any branch of the Armed Forces of the United States, including active duty as a reservist, and active service in the commissioned corps of the Public Health Service or the National Oceanic and Atmospheric Administration.

BRANCH OF SERVICE	FROM			TO			DISCHARGE (Honorable or Dishonorable)
	Year	Month	Day	Year	Month	Day	
Prior service time, basic training, first AIT/tech school, deployment.							

8. Do you claim any type of veterans' preference which has not been verified?
☐ No ☐ Yes — Check one of the statements, if it applies to you. I claim preference as the:
☐ Spouse of a disabled veteran ☐ Mother of a deceased or disabled veteran ☐ Unmarried widow/widower of a veteran

9. **CERTIFICATION:** The prior Federal civilian and uniformed service listed on my application/resume and listed above constitutes my entire record of Federal employment. I have no other Federal service for which I want to claim credit.

Signature	Date

*U.S. Government Printing Office: 1996 - 404-761/32401

Everyone

Designation of Beneficiary

Unpaid Compensation of Deceased Civilian Employee

Important:
Read all instructions before filling in this form

A. Identification

Name *(Last, first, middle)*	Date of birth *(mm, dd, yyyy)*	Social Security Number

Department or agency in which presently employed *(or former department or agency)*:

Department or agency	Bureau	Division	Location *(City, state and ZIP code)*
Depts of the Army & Air Force	National Guard of Hawaii	Office of TAG (HRO-M)	Honolulu, HI 96816-4495

I, the employee named above, canceling any and all previous Designations of Beneficiary heretofore made by me, do now designate the beneficiary or beneficiaries named below to receive any **unpaid compensation** due and payable after my death. I understand that this Designation of Beneficiary relates solely to money due as defined in 5 U.S.C. 5581, 5582, 5583, and in no way will affect the disposition of any benefit which may become payable under the Retirement or Group Life Insurance Acts applicable to my Government service. I further understand that this Designation of Beneficiary will remain in full force and effect until (1) I expressly change or revoke it in writing, (2) I transfer to another agency, or (3) I am reemployed by the same or another department or agency of the Government.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary	Address (Including ZIP code) of each beneficiary	Relationship	Share to be paid to each beneficiary
Date of designation *(mm, dd, yyyy)*	Your signature		Total = %

Optional for Conversions if in eOPF already

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Number and street	City, state and ZIP code
Signature of witness	Number and street	City, state and ZIP code

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received	Signature	Date

Type or print your return address to insure return

Home Address

Everyone

TRS AND FEHB ACKNOWLEDGMENT FORM

(Revised 15 December 2014)

The John Warner National Defense Authorization Act for 2007 (P.L. 109-364), signed by President George W. Bush on 17 October 2006, excludes individuals eligible for health insurance under the Federal Employees Health Benefits (FEHB) Program from coverage under TRICARE Reserve Select (TRS).

The following chart reflects eligibility to enroll or continue coverage under TRS:

	Eligible for FEHB	Enrolled In FEHB	Eligible for FEHB through a family member	Enrolled in FEHB through a family member	Enroll In TRS?
Selected Reserve Member	No	No	N/A	N/A	Yes
Selected Reserve Member	Yes	No	N/A	N/A	No (if eligible for FEHB, cannot enroll in TRS)
Selected Reserve Member	Yes	Yes	N/A	N/A	No (if eligible for or enrolled in FEHB, cannot enroll in TRS)
Selected Reserve Member	No	No	Yes	No	Yes (however cannot enroll in both FEHB and TRS)
Selected Reserve Member	No	No	Yes	Yes	No (if enrolled in FEHB, cannot enroll in TRS)
Family Member	Yes	No	N/A	N/A	Yes (however cannot enroll in both FEHB and TRS)
Family Member	Yes	Yes	N/A	N/A	No (if enrolled in FEHB, cannot enroll in TRS)

You were recently hired as a permanent or indefinite federal employee. This makes you *eligible* to enroll in the FEHB program. Upon *eligibility* for FEHB, you must contact TRICARE West Region's Contractor, UnitedHealthcare Military & Veterans, Customer Service at 1-877-988-9378 and notify them of your FEHB eligibility and cancel your TRS coverage immediately.

If you are a temporary employee, you will be *eligible* to enroll in the FEHB when the temporary appointment is expected to be for 90 consecutive days or more. If your initial appointment is less than 90 consecutive days, you will be considered to be in a 90-day waiting period before you will be eligible to enroll. If the appointment is extended without a break in service to 90 consecutive days or more, you will be notified, and information regarding your FEHB eligibility will be provided to you. Upon *eligibility*, whether or not you elect to enroll in the FEHB program, you must contact TRICARE West Region's Contractor, UnitedHealthcare Military & Veterans, Customer Service at 1-877-988-9378 and notify them of your FEHB eligibility and cancel your TRS coverage immediately.

If you have any questions about how to terminate your TRS enrollment, contact UnitedHealthcare Military & Veterans Customer Service at the phone number above or their web site at www.uhcmilitarywest.com.

If you fail to end your TRS coverage as required, TRICARE will terminate your coverage retroactive to when you became eligible for FEHB and you will be responsible for any health care costs after the effective date of termination. You could also face a fine and/or a charge of fraud.

Please sign and date this letter to acknowledge receipt of this information. A signed copy of this document will be filed in your Electronic Official Personnel Folder (eOPF).

_____ _____

(SIGNATURE) (DATE)

_____

(PRINTED NAME)

Everyone

U.S. Office of Personnel Management Guide to Personnel Data Standards	**ETHNICITY AND RACE IDENTIFICATION** (Please read the Privacy Act Statement and instructions before completing form.)	
Name (Last, First, Middle Initial)	Social Security Number	Birthdate (Month and Year)
Agency Use Only		

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested unde ve Order 9397, which requires SSN be used for the purpose of uniform, orderly administration viding this information is voluntary and failure to do so will have no effect on your employment s ded, however, other agency sources may be used to obtain it.

Optional for Conversions if in eOPF already

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ Yes ☐ No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
☐ American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
☐ Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐ Black or African American	A person having origins in any of the black racial groups of Africa.
☐ Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐ White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

Everyone

SELF-IDENTIFICATION OF DISABILITY

(Please read the Privacy Act information and additional instructions on Page 2)

Name (Last, First, Middle Initial)	Date of Birth (MM/YYYY)	Social Security Number

Purpose:

Each agency in the Executive Branch of the Federal government has established programs to facilitate the hiring, placement, and advancement of individuals with disabilities. Self-identification of disability status is essential for effective data collection and analysis of the Federal government's efforts. While self-identification is voluntary, your cooperation in providing accurate information is critical to these efforts. Every precaution is taken to ensure that the information provided by each employee is kept in the strictest confidence.

ENTER CODE HERE → ☐☐

Targeted Disabilities or Serious Health Conditions:

02- Developmental Disability, for example, autism spectrum disorder
03- Traumatic Brain Injury
19- Deaf or serious difficulty hearing, benefiting from, for example, American Sign Language, CART, hearing aids, a cochlear implant and/or other supports
20- Blind or serious difficulty seeing even when wearing glasses
31- Missing extremities (arm, leg, hand and/or foot)
40- Significant mobility impairment, benefiting from the utilization of a wheelchair, scooter, walker, leg brace(s) and/or other supports
60- Partial or complete paralysis (any cause)
82- Epilepsy or other seizure disorders
90- Intellectual disability
91- Significant Psychiatric Disorder, for example, bipolar disorder, schizophrenia, PTSD, or major depression
92- Dwarfism
93- Significant disfigurement, for example, disfigurements caused by burns, wounds, accidents, or congenital disorders

Other Options:

01- I do not wish to identify my disability or serious health condition.
05- I do not have a disability or serious health condition.
06- I have a disability or serious health condition, but it is not listed on this form.

Other Disabilities or Serious Health Conditions:

13- Speech impairment
41- Spinal abnormalities, for example, spina bifida or scoliosis
44- Non-paralytic orthopedic impairments, for example, chronic pain, stiffness, weakness in bones or joints, some loss of ability to use part or parts of the body
51- HIV Positive/AIDS
52- Morbid obesity
59- Nervous system disorder for example, migraine headaches, Parkinson's disease, or multiple sclerosis
80- Cardiovascular or heart disease
81- Depression, anxiety disorder, or other psychiatric disorder
83- Blood diseases, for example, sickle cell anemia, hemophilia
84- Diabetes
85- Orthopedic impairments or osteo-arthritis
86- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
87- Kidney dysfunction
88- Cancer (present or past history)
94- Learning disability or attention deficit/hyperactivity disorder (ADD/ADHD)
95- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome, colitis, celiac disease, dysphexia
96- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis
97- Liver disease, for example, hepatitis or cirrhosis
98- History of alcoholism or history of drug addiction (but not currently using illegal drugs)
99- Endocrine disorder, for example, thyroid dysfunction

Title 32 Only

CONDITION OF EMPLOYMENT

The regulations that govern the employment of National Guard technicians require membership in an appropriate National Guard unit as a condition of employment. This requirement is derived from Section 709(f)(1), Title 32, United States Code.

This is to certify that I understand that my full-time technician position with the Hawaii Air/Army National Guard is contingent upon my maintaining membership with the Hawaii Air/Army National Guard. Should I lose my membership for any reason, I will be terminated from my full-time technician position.

_____

(Printed Name)

_____

(Signature)

_____

(Date)

Temp

MEMORANDUM OF UNDERSTANDING - TEMPORARY APPOINTMENT

(Revised 15 December 2014)

I, the undersigned, understand that ***(please initial next to each item below)***:

1. This appointment is *subject to termination at any time* without the use of adverse action or reduction-in-force procedures. Notice will be provided by Standard Form 50 (Notification of Personnel Action). Initial ____

2. A temporary *limited* employee:

a. Does not acquire permanent status under a temporary limited appointment or eligibility to be noncompetitively converted to a permanent appointment. Initial ____

b. Does not serve a probationary or trial period. Initial ____

c. Is not eligible for coverage under the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), or the Federal Employees Group Life Insurance (FEGLI) Program--*unless* the temporary employment follows, without a break in service in excess of three days, employment in a covered position. In addition, temporary service performed on or after 1 January 1989 is not creditable under FERS even if the employee later becomes covered by FERS. Since I am not currently eligible for a federal retirement program, I may be eligible to enroll in a "*my*RA" (*my*Retirement Acccount) savings account with the U.S. Treasury Department (https://myra.treasury.gov/). Initial ____

d. Is eligible for coverage under the Federal Employees Health Benefits (FEHB) Program when the temporary appointment is expected to be for 90 consecutive days or more in a continuous appointment. Employees may also carry over FEHB coverage when they move from a covered position to a temporary appointment without a break in service in excess of three days. Initial ____

(1) If your initial appointment is less than 90 consecutive days, you will be considered to be in a 90-day waiting period before you will be eligible to enroll. If your appointment is extended without a break in service to 90 or more consecutive days, you will be notified, and information regarding your FEHB eligibility will be provided to you. Initial ____

(2) Upon *eligibility* for FEHB, a dual status technician becomes *ineligible* for TRICARE Reserve Select (TRS) and must contact TRICARE to disenroll in TRS whether or not he/she enrolls in the FEHB. Initial ____

e. Is not eligible for coverage under the Federal Dental and Vision Program (FEDVIP). However, is eligible to enroll in the Flexible Spending Account (FSA) and the Long Term Care Insurance (FLTCIP) programs. Initial ____

f. Is not eligible for within-grade increases (WIGI) when serving in a General Schedule (GS) position, even when that temporary limited appointment has been extended beyond one year. An employee serving under a temporary limited appointment in a Federal Wage System (WG/WL/WS) position is eligible for a WIGI when the required waiting periods are met and job performance is fully acceptable or higher. Initial ____

g. Is eligible to work on a part-time, intermittent, or full-time basis if the agency authorizes such an appointment. Initial ____

h. Earns leave when appointed to a position with a regularly scheduled tour of duty, either part-time or full-time. All regularly scheduled temporary employees earn sick leave, and those whose temporary appointments are made for 90 consecutive days or more also earn annual leave. Temporary employees serving on temporary limited appointments not to exceed one year are *not* eligible for military leave. Extensions of or continuous consecutive temporary appointments, which result in more than one year of consecutive service are also not eligible for military leave since each extension or conversion action is considered a new appointment for military leave purposes. Initial ____

i. Is not covered by adverse action procedures under 5 USC 4303 and 5 USC 7511 even when converted to a new temporary limited appointment with total service extending beyond one year because each temporary appointment is always limited to one year or less. Initial ____

j. Does not have the protection of reduction-in-force procedures. Initial ____

3. The regulations that govern the employment of National Guard technicians require membership in an appropriate National Guard unit as a condition of employment. This requirement is derived from Section 709(f)(1), Title 32, United States Code. I certify that I understand that my full-time technician position with the Hawaii Air/Army National Guard is contingent upon my maintaining membership with the Hawaii Air/Army National Guard. Should I lose my membership for any reason, I will be terminated from my full-time technician position. Initial ____

4. Dual-Status military technicians are required to wear the uniform appropriate for the member's grade and component of the armed services while performing duties. The uniform will be worn in compliance with the regulations issued by the applicable military component. Initial ____

Please sign and date below to acknowledge receipt of this information. A signed copy of this document will be filed in your Electronic Official Personnel Folder (eOPF).

_____

Signature

_____

Printed Name

_____

Date

Temp & Perm

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

▶ **START HERE:** **Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: _____
OR
2. Form I-94 Admission Number: _____
OR
3. Foreign Passport Number: _____
Country of Issuance: _____

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

STOP *Employer Completes Next Page* STOP

Temp & Perm

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		1. A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		3. School ID card with a photograph		3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		4. Voter's registration card		4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		5. U.S. Military card or draft record		5. Native American tribal document
		6. Military dependent's ID card		6. U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		8. Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are un…ent Collect document(s) 10. S… 11. C…rd 12. Day-care or nursery …cord		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI				

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Temp & Perm

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name *(Family Name)*	First Name *(Given Name)*	M.I.	Citizenship/Immigration Status

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*		Expiration Date *(if any)(mm/dd/yyyy)*
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				
Document Title				
Issuing Authority				
Document Number				
Expiration Date *(if any)(mm/dd/yyyy)*				

Additional Information

Whoever does e-Verify will fill out

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

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions)***

Signature of Employer or Authorized Representative	Today's Date*(mm/dd/yyyy)*	Title of Employer or Authorized Representative

Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative	Employer's Business or Organization Name

Employer's Business or Organization Address (Street Number and Name)	City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)*			B. Date of Rehire *(if applicable)*
Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Date *(mm/dd/yyyy)*

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

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

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date *(mm/dd/yyyy)*	Name of Employer or Authorized Representative

Temp & Perm

EMPLOYEE EDUCATIONAL DATA

PRIVACY ACT NOTICE: In accordance with the provisions of the Privacy Act of 1974 protecting against unwarranted invasion of individual privacy, this information is not to be reproduced or used for any other purpose and will be adequately protected under lock and key while it is in the recipient's custody. It will be disposed of by burning, shredding, or pulping in such a manner that the above intent is carried out.

INSTRUCTIONS: Please complete this form according to the instructions and return it to the Human Resources Office. In order to keep your education record up-to-date, be sure to notify the personnel office whenever you attain a higher level of education than the level you show on this form. If you have any questions, please contact the **HRO Services Section at 733-4116.**

LAST NAME-FIRST NAME-MIDDLE INITIAL OF EMPLOYEE	SOCIAL SECURITY NUMBER

EDUCATION LEVEL: **(Refer to Attachment 1)** - Insert the code in the box to the right which best represents the **HIGHEST** level of education you have attained.

YEAR GRADUATED: Insert in the boxes to the right the last two digits of the year in which you attained your highest level of education. **(This includes year graduated High School.)**

INSTRUCTIONAL PROGRAM: **(Refer to Attachment 2)** - Insert the six-digit code in the boxes to the right that best describes your major field of study.

NUMBER OF CREDIT HOURS: Enter total number of hours.

TYPE OF CREDIT HOURS: Enter: "1" for Semester Hours, or "2" for Quarter Hours

TYPE OF SCHOOL & NAME OF COLLEGE:
Enter in the box to the right ONE of the following codes and the name of the college attended.

(B) Junior College
(C) College or University
(H) High School
(S) Secretarial, Business or Commercial School
(V) Vocational, Trade or Tech School (High School Level)
(W) Vocational, Trade or Tech School (Above High School)

EMPLOYEE'S SIGNATURE:	DATE:

Perm

FERS
Federal Employees Retirement System

Designation of Beneficiary

Federal Employees Retirement System

Form Approved
OMB No. 3206-0173

Important:
Read all instructions before filling in this form

A. Identification

Name *(Last, first, middle)*	Date of birth *(mm/dd/yyyy)*	Social Security Number

Place an "X" in the appropriate box: ☐ An employee ☐ Retired or an applicant for retirement ☐ Former employee eligible for retirement in the future

If you are retired give your claim number

Department or agency in which presently employed *(or former department or agency)*:

Department or agency	*Bureau*	*Division*	*Location (City, state and ZIP code)*
Depts of the Army & Air Force	National Guard of Hawaii	Office of TAG (HRO-M)	Honolulu, HI 96816-4495

I, the individual identified above, designate the beneficiary or beneficiaries named below to receive any lump-sum benefit which may become payable under the Federal Employees Retirement System (FERS) after my death, including lump-sum death benefits which may become payable based on amounts contributed to the Civil Service Retirement System (CSRS) before I became covered by FERS. I understand that this designation of beneficiary cancels any previous FERS or CSRS designation of beneficiary, and that it remains in effect until I cancel it in writing or I receive payment of my FERS retirement contributions.

I direct, unless otherwise indicated below, that if more than one beneficiary is named, the share of any beneficiary who may predecease me or who may be disqualified for any other reason, shall be distributed equally among the stated beneficiaries, or entirely to the survivor. If none of the beneficiaries are alive and eligible to receive payment when a lump-sum payment becomes payable, this designation is void, and payment will be made according to the order of precedence set by law.

B. Information Concerning The Beneficiaries (See Examples of Designations):

First name, middle initial, and last name of each beneficiary ❶	Address (Including ZIP code) of each beneficiary ❷	Relationship to you ❶	Share to be paid to each beneficiary
Date of designation *(mm/dd/yyyy)*	Your signature		Total = 100%

Optional for Conversions if in eOPF already

C. Witnesses (A witness is not eligible to receive payment as a beneficiary):

We, the undersigned, certify that this statement was signed in our presence.

Signature of witness	Address *(including ZIP code)*
Signature of witness	Address *(including ZIP code)*

Receiving agency certification

I have reviewed this designation and certify that the designated shares total 100% and that no witnesses are designated as beneficiaries.

Date received by agency *(mm/dd/yyyy)*	*Signature*	*Date (mm/dd/yyyy)*

❶ We will pay to the person you designate, even if that person's name or relationship to you changes after you file this designation. For example, suppose you designate your spouse and then you two divorce and you marry someone else. We will pay any lump sum to your former spouse unless you submit another designation to cancel prior designations or to designate who we are to pay.

❷ We will write to the address you provide here to contact the person you designate. However, that person is obligated to get in touch with us after your death to ask us to make payment.

Type or print your return address so that we can return a copy to you.

See Back of Employee Copy For Instructions On Where To File This Form.
(Retain until employee leaves Federal service and then send to the Office of Personnel Management [OPM].)

Perm

FEGLI
Federal Employees Group Life Insurance

Designation of Beneficiary
Federal Employees' Group Life Insurance (FEGLI) Program
(DO NOT erase or cross-out. Use a new form.)

Form Approved
OMB No. 3206-0136

Important:
Read instructions on the Back of Part 2 before completing this form.

A. Information About the Insured (not the Assignee, if there is one) (type or print)

Name of Insured *(Last, first, middle)*	Date of birth of Insured *(mm/dd/yyyy)*	Social Security Number of Insured

The Insured is: *Place an "X" in the appropriate box.*

- [X] an employee
- [ ] a retiree
- [ ] a compensationer

If the Insured is retired or receiving Federal Employees' Compensation, give CSA, CSI, or OWCP claim number:

Department or agency where the Insured works *(If retired, last department or agency where the Insured worked):*

Department or agency	Bureau or division	Location *(city, state, and ZIP code)*
Departments of the Army & Air Force	NGHI, TAG-HI, HRO-M	Honolulu, HI 96816-4495

B. Information About the Beneficiary or Beneficiaries (See Back of Part 1 for examples) (type or print)

First name, middle initial, and last name of each beneficiary	Social Security Number	Address *(Including ZIP code)*	Relationship	Percent or fraction designated

Optional for Conversions if in eOPF already

Total (Must equal 100% or 1.0) (Do not use dollar amounts) →

(Do not put a Total if you designated types of insurance. See example 4 on Back of Part 1.)

C. Statement of Insured or Assignee (type or print)

Your name and address *(Including ZIP code)*	Please check one: I am:	Please check all three:
	[ ] the Insured	[ ] I have not assigned the insurance.
	[ ] an Assignee	[ ] Two people who witnessed my signature signed below.
	See Back of Part 2 for definitions	[ ] I did not name either witness as a beneficiary.

I understand that if there is a valid assignment on file, only the assignee has the right to designate a beneficiary. If a valid assignment is not on file, but there is a valid court order on file with the agency or the U.S. Office of Personnel Management, as appropriate, any designation I complete for the same benefits is not valid.

I understand that if this Designation is valid, it will stay in effect unless it is canceled. (See "When Is A Designation Canceled?" on the Back of Part 2).

I understand that if this Designation is invalid for any reason, the Office of Federal Employees' Group Life Insurance will pay benefits according to the next most recent valid designation. If there isn't one, it will pay according to the order listed on the Back of Part 2.

I am canceling any and all previous Designations of Beneficiary under the Federal Employees' Group Life Insurance Program and am now designating the beneficiary(ies) named above.

Signature of Insured/Assignee *(Only the Insured/Assignee may sign. Signatures by guardians, conservators or through a power of attorney are not acceptable.)* This form is not valid unless the Insured/Assignee signs in this box.	Date *(mm/dd/yyyy)*
➲	

D. Witnesses To Signature (A witness is not eligible to receive a payment as a beneficiary.)

Signature of witness	Address *(Including ZIP code)*
➲	
Signature of witness	Address *(Including ZIP code)*
➲	

E. For Agency Use Only (or OPM, as appropriate)

Receiving agency	Date of receipt *(mm/dd/yyyy)*	Signature of authorized official	Title

Part 1 - Original

HAWAII DEPARTMENT OF DEFENSE BADGE REQUEST FORM

TO BE COMPLETED BY ID ISSUER

BADGE NUMBER: _____ BADGE ISSUE/ EXPIRATION DATE: _____ / _____

TO BE COMPLETED BY BADGE REQUESTOR

NAME: _____
LAST FIRST MI

RANK / TITLE: _____

ORGANIZATION: _____

UNIT: _____ OFFICE _____

PHONE NUMBER _____

TYPE OF APPOINTMENT: _____
Permanent/Indefinite/Temporary/Re-employ

NOT TO EXCEED DATE (NTE): _____

_____
REQUESTOR SIGNATURE

If your current badge is expired or lost, or if you have never been issued a HI DoD Badge, please have your Military or State Supervisor sign below. Please bring this completed form on the day of badge processing, and bring your photo ID card (i.e. Military ID, driver's license, etc.)

_____
SUPERVISOR'S PRINTED NAME

_____
SUPERVISOR'S SIGNATURE

*DoD Contractors who have a contract for less than 1 year will NOT receive a HI DoD Badge.

FOR J3 / JOINT OPERATIONS CENTER USE ONLY:

NEW ISSUE: ☐

LOST: ☐

EXPIRED: ☐

RENEW: ☐

ISSUED BY:

_____
PRINT NAME

_____
SIGNATURE

REMARKS:

_____