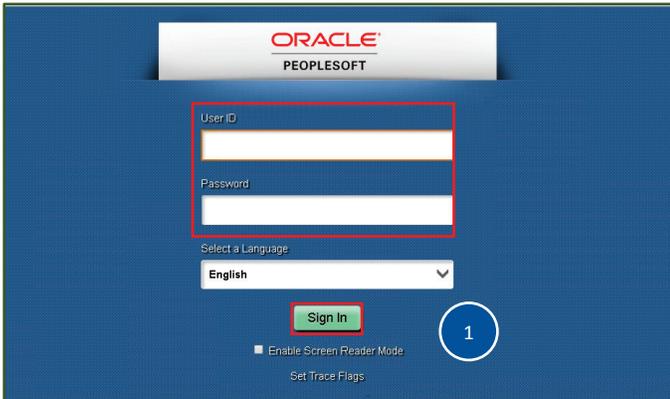




This topic will cover the following: On-Boarding.

1 Log in to **PeopleSoft**.



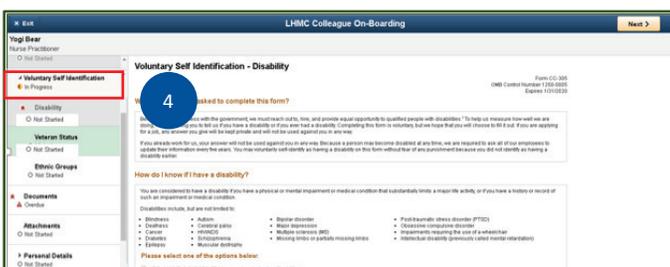
2 Click **OnBoarding** tile from the Employee Self Service (ESS) home.



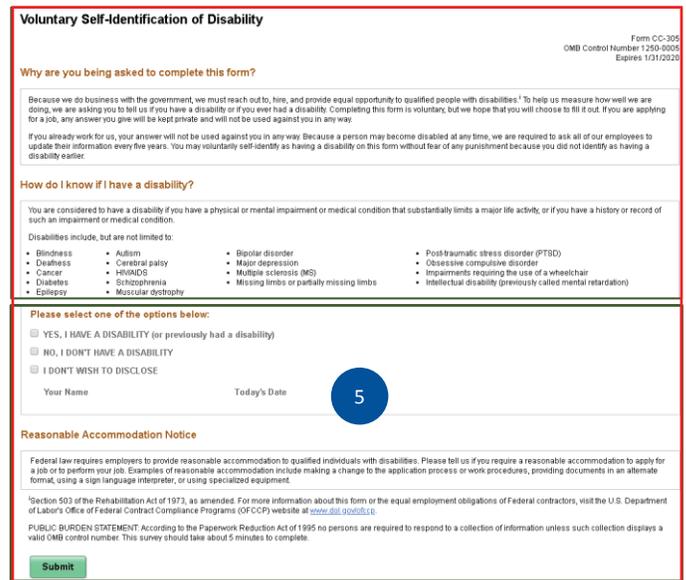
3 Click **Onboarding Activities** tile



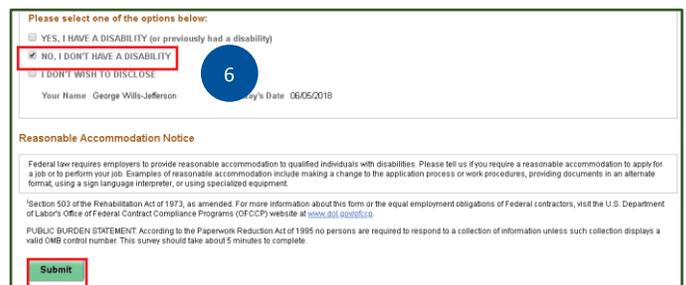
4 Click **Voluntary Self-Identification - Disability** link.



5 Review the **Voluntary Self-Identification - Disability** information page.

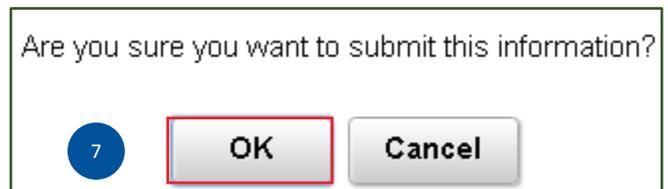


6 Select an **option** under the Please select one of the options below section and click **Submit**.

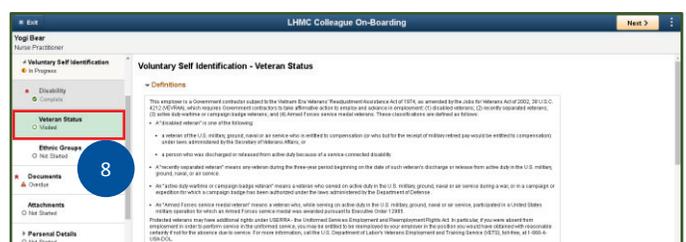


Note: Option selection will populate your name and the current system date which will serve as your electronic signature.

7 Click **OK**.



8 Click **Voluntary Self-Identification - Veteran Status** link.





9 Review the **Voluntary Self-Identification – Veteran Status** information page.

Voluntary Self Identification - Veteran Status

Definitions

This employer is a Government contractor subject to the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA), which requires Government contractors to take affirmative action to employ and advance in employment (1) disabled veterans, (2) recently separated veterans, (3) active duty wartime or campaign badge veterans, and (4) Armed Forces service medal veterans. These classifications are defined as follows:

- A "disabled veteran" is one of the following:
 - a veteran of the U.S. military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs, or
 - a person who was discharged or released from active duty because of a service-connected disability.
- A "recently separated veteran" means any veteran during the three-year period beginning on the date of such veteran's discharge or release from active duty in the U.S. military, ground, naval, or air service.
- An "active duty wartime or campaign badge veteran" means a veteran who served on active duty in the U.S. military, ground, naval or air service during a war, or in a campaign or expedition for which a campaign badge has been authorized under the laws administered by the Department of Defense.
- An "Armed Forces service medal veteran" means a veteran who, while serving on active duty in the U.S. military, ground, naval or air service, participated in a United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12958.

Protected veterans may have additional rights under USERRA - the Uniformed Services Employment and Reemployment Rights Act. In particular, if you were absent from employment in order to perform service in the uniformed service, you may be entitled to be reemployed by your employer in the position you would have obtained with reasonable certainty if not for the absence due to service. For more information, call the U.S. Department of Labor's Veterans Employment and Training Service (VETS), toll-free, at 1-866-4-USA-DOL.

Self-Identification

As a Government contractor subject to VEVRAA, we are required to submit a report to the United States Department of Labor each year identifying the number of our employees belonging to each specified "protected veteran" category. If you believe you belong to any of the categories of protected veterans listed above, please indicate by selecting the appropriate option below.

I am a veteran type not listed

I am a protected veteran.

I am NOT a protected veteran.

I do not wish to disclose this information

Reasonable Accommodation Notice

If you are a disabled veteran it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for your disability.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations, (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment, and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

Submit

10 Make a selection and click **Submit**.

Self-Identification

As a Government contractor subject to VEVRAA, we are required to submit a report to the United States Department of Labor each year identifying the number of our employees belonging to each specified "protected veteran" category. If you believe you belong to any of the categories of protected veterans listed above, please indicate by selecting the appropriate option below.

I am a veteran type not listed

I am a protected veteran.

I am NOT a protected veteran.

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Reasonable Accommodation Notice

If you are a disabled veteran it would assist us if you tell us whether there are accommodations we could make that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations. This information will assist us in making reasonable accommodations for your disability.

Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in ways that are not inconsistent with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended.

The information you submit will be kept confidential, except that (i) supervisors and managers may be informed regarding restrictions on the work or duties of disabled veterans, and regarding necessary accommodations, (ii) first aid and safety personnel may be informed, when and to the extent appropriate, if you have a condition that might require emergency treatment, and (iii) Government officials engaged in enforcing laws administered by the Office of Federal Contract Compliance Programs, or enforcing the Americans with Disabilities Act, may be informed.

Submit

11 Click **Voluntary Self Identification – Ethnic Groups** link and click **Add an Ethnic Group** button.

HRHC Colleague On-Boarding

Yogi Dear
Nurse Practitioner

Voluntary Self Identification - Ethnic Groups

No data exists.

Add an Ethnic Group

11

The employer is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, the employer invites employees to voluntarily self-identify their race or ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.

12 Click the **magnifying glass** in the Ethnic Group field.

Ethnic Group

*Ethnic Group

12

13 Make a **selection** from the list.

Lookup

Search for: "Ethnic Group"

Search Criteria

Search Results

Ethnic Group	Description
AMIND	American Indian or Alaskan Native
ASIAN	Asian American
BLACK	Black or African American, not of Hispanic Origin
HSPA	Hispanic or Latino
NSPEC	I do not wish to disclose
PACIF	Native Hawaiian or Other Pacific Islander
WHITE	White, not of Hispanic Origin
ZZMORE	2 or More Race

13

14 Click **Save**.

Ethnic Group

*Ethnic Group

14

Save

Delete

15 Your updated information is shown below.

Employee Self Service

Personal Details

George Wills-Jefferson
VP of Governance & Security

Ethnic Groups

2 or More Race

15

Voluntary Self-Identification

The employer is subject to certain governmental recordkeeping and reporting requirements for the administration of civil rights laws and regulations. In order to comply with these laws, the employer invites employees to voluntarily self-identify their race or ethnicity. Submission of this information is voluntary and refusal to provide it will not subject you to any adverse treatment. The information obtained will be kept confidential and may only be used in accordance with the provisions of applicable laws, executive orders, and regulations, including those that require the information to be summarized and reported to the federal government for civil rights enforcement. When reported, data will not identify any specific individual.



16 Click **Emergency Contacts** under Personal Details and **Add Emergency Contact** button.

17 Enter **Contact Name**.

18 Select a **Relationship** by clicking on the drop-down arrow in Relationship field.

19 Click **Add Address**.

20 Enter address information and click **Done**.

Note: You can click on **Same as mine** check box if your emergency contact has same address as yours.

21 Click **Add Phone Number**.



22 Enter phone number information and click **Done**.

23 Click **Save**.

24 Your updated information is shown below.

25 Click **Verify Contact Details** and review.

26 Click **Benefits** link.

Note: When you click on Enroll, the “Enrollment Elections Summary” form will open up. This form will list your available benefits. You will see an Edit button next to each available benefit; clicking on the **Edit** button will expand that benefit and provide you with the cost and other selection options. As you select each benefit, you can scroll down to the bottom of the form to see the cost impact. This Tip Sheet will show you how to select the Medical benefit, then just follow the same steps to select other benefits.

27 Click **Edit** button next to Medical.

	Full Cost	Lahey Paid	Before Tax Deduction	After Tax Deduction
Current: No Coverage				
New: Waive	0.00	0.00		
Edit Dental				
Current: No Coverage				
New: Waive	0.00	0.00		
Edit Vision				
Current: No Coverage				
New: Waive	0.00	0.00		
Edit Health Care FSA				
Current: No Coverage				
New: Waive	0.00	0.00	0.00	
Edit Dependent Care FSA				
Current: No Coverage				
New: Waive	0.00	0.00	0.00	
Edit Basic Life				
Current: No Coverage				
New: BLF 1X: Salary X 1 : \$125,000	2.02	2.02		
Edit Supplemental Life				
Current: No Coverage				
New: Waive	0.00	0.00		
Edit Accidental Death/Dismemberment				
Current: No Coverage				
New: Waive	0.00	0.00		
Edit Child Life				
Current: No Coverage				
New: Waive	0.00	0.00		
Edit Spousal Life				
Current: No Coverage				
New: Waive	0.00	0.00		



Basic Long Term Disability

Current: No Coverage
 New: **Basic LTD 60% of Eligible Pay; 60.00% of Salary** 34.94 34.94

Legal Plan

Current: Waive
 New: Waive 0.00 0.00

Employee Assistance Program

Current: Employee Assistance Plan
 New: Employee Assistance Plan 0.00 0.00

Buy-Up Long Term Disability

Current: No Coverage
 New: No Coverage

This table summarizes estimated costs for your new benefit choices. (The "Employer" column displays the amount that Lahey Health is contributing to subsidize the cost of your benefits.)

	Before Tax Deduction	After Tax Deduction	Total
Full Cost			36.96
Lahey Paid			-36.96
Your Deduction	0.00	0.00	0.00

Some of these costs are based on your regularly scheduled hours and pay rate. These costs may change if your regularly scheduled hours or pay rate change.

Select your Lahey Health benefits, then click **Submit** to send your final choices through Colleague Connection.

Important: Your enrollment will not be complete until you submit your choices through Colleague Connection.

Benefits Enrollment

Medical

George Willis-Jefferson

There are several choices of medical plans. Below are the options and costs for your medical coverage. Cost is based on your regularly scheduled work hours. Your 2018 Wellness Incentive, if applicable, will be added to your paycheck each pay period in 2018.

[Click here for more information on the medical plan options](#)

Important! Your current coverage is: No Coverage. Coverage for this plan will be waived if you do not make an election.

Select an Option

Here are your available options with your deduction:
 (Your Deduction = Full Cost - Lahey Paid)

[\[Overview of the Plan Costs\]](#)

Select one of the following plans:

HP-Lahey Health Value HMO [Search for providers in this plan](#)

Important Note: Selection of a PCP is required.

Coverage Level	Full Cost	Lahey Paid	Your Deduction
Individual	\$355.24	\$283.49	\$71.75
Individual plus Spouse	\$923.83	\$739.86	\$183.77
Individual plus Child(ren)	\$710.48	\$556.94	\$153.54
Individual plus Family	\$1,065.73	\$831.32	\$234.41

HP-Lahey Health Select HMO-OOA [Search for providers in this plan](#)

Important Note: Selection of a PCP is required.

Coverage Level	Full Cost	Lahey Paid	Your Deduction
Individual	\$373.94	\$279.39	\$94.55
Individual plus Spouse	\$972.23	\$747.80	\$224.43
Individual plus Child(ren)	\$747.87	\$556.86	\$191.01
Individual plus Family	\$1,121.81	\$837.98	\$283.83

Harvard Pilgrim PPO

Important Note: No PCP is required.

Coverage Level	Full Cost	Lahey Paid	Your Deduction
Individual	\$512.29	\$279.09	\$233.20
Individual plus Spouse	\$1,331.96	\$738.46	\$593.50
Individual plus Child(ren)	\$1,024.59	\$556.32	\$468.27
Individual plus Family	\$1,536.89	\$830.39	\$706.50

HP-Lahey Health Preferred HMO [Search for providers in this plan](#)

Important Note: Selection of a PCP is required.

Coverage Level	Full Cost	Lahey Paid	Your Deduction
Individual	\$326.83	\$283.75	\$43.08
Individual plus Spouse	\$849.74	\$757.43	\$92.31
Individual plus Child(ren)	\$653.64	\$578.41	\$75.23
Individual plus Family	\$980.47	\$842.01	\$138.46

Waive

Select the **Update and Continue** button to store your choice until you are ready to submit your final enrollment on the Enrollment Summary.

Select the **Discard Changes** button to ignore all entries made on this page and return to the Enrollment Summary.

Note: When you select a plan, the "Enroll your Dependents" form will open up. If the plan you selected requires a PCP, you would also see the "Choose a Primary Care Provider ID" form.

HP-Lahey Health Preferred HMO [Search for providers in this plan](#)

Important Note: Selection of a PCP is required.

Coverage Level	Full Cost	Lahey Paid	Your Deduction
Individual	\$326.83	\$283.75	\$43.08
Individual plus Spouse	\$849.74	\$757.43	\$92.31
Individual plus Child(ren)	\$653.64	\$578.41	\$75.23
Individual plus Family	\$980.47	\$842.01	\$138.46

Waive

Enroll Your Dependents

The definition of an eligible dependent includes:

- Legal spouse
- Children and step children to age 26 and disabled dependents to any age; and
- Children of your eligible covered children and stepchildren

If an individual is missing from the list, s/he does not meet the eligibility criteria. You may use the Add/Review Dependents button below to add or change dependent information.

You may enroll any of the following individuals for coverage under this plan by checking the Enroll box next to the dependent's name.

Enroll	Name	Relationship
<input checked="" type="checkbox"/>	Martha Jefferson	Spouse

Choose a Primary Care Provider ID

Enrollment in this plan requires that you select a primary care provider. You must indicate whether or not you have already established a relationship with this provider, since some providers are not accepting new patients. To find your Primary Care Physicians PCP ID#, click on Select a Provider link below.

Specify a Primary Care Provider ID #:

Check here if you are an existing patient of this provider.

Check here to use the same provider for all your dependents

[Click here to Select a Provider for your Dependent\(s\).](#)

Select the **Update and Continue** button to store your choice until you are ready to submit your final enrollment on the Enrollment Summary.

Select the **Discard Changes** button to ignore all entries made on this page and return to the Enrollment Summary.

29 Enter Primary Care Provider ID # and if applicable place check marks in the boxes below.

Choose a Primary Care Provider ID

Enrollment in this plan requires that you select a primary care provider. You must indicate whether or not you have already established a relationship with this provider, since some providers are not accepting new patients. To find your Primary Care Physicians PCP ID#, click on Select a Provider link below.

Specify a Primary Care Provider ID #: AA312422

Check here if you are an existing patient of this provider.

Check here to use the same provider for all your dependents

[Click here to Select a Provider for your Dependent\(s\).](#)

Select the **Update and Continue** button to store your choice until you are ready to submit your final enrollment on the Enrollment Summary.

Select the **Discard Changes** button to ignore all entries made on this page and return to the Enrollment Summary.

Note: You can also click on the "Select a Provider" link for this plan. It will take you to the Harvard Pilgrim Health Care/Lahey portal from which you can get the provider ID number to enter here. If you are enrolling in a HMO plan, each enrolled member must have a PCP ID number listed.

30 Click on Update and Continue.

28 Click the radio button to select a plan.



Choose a Primary Care Provider ID

Enrollment in this plan requires that you select a primary care provider. You must indicate whether or not you have already established a relationship with this provider, since some providers are not accepting new patients. To find your Primary Care Physicians PCP ID#, click on Select a Provider link below.

Specify a Primary Care Provider ID #: Select a Provider

Check here if you are an existing patient of this provider.

Check here to use the same provider for all your dependents

Click here to Select a Provider for your Dependents.

Select the **Update and Continue** button to store your choice until you are ready to submit your final enrollment on the Enrollment Summary screen.

Select the **Discard Changes** button to ignore all entries made on this page and return to the Enrollment Summary.

31 Review Summary screen and click on Update Elections.

Benefits Enrollment

Medical

George Wills-Jefferson

i Important: Your enrollment will not be complete until you submit your choices online through Colleague Connection.

Your Choice

You have chosen HP- Lahey Health Preferred HMO with Individual plus Spouse coverage.

Your Estimated per-pay-period Deduction

Full Cost	\$849.74
Lahey Paid	\$757.43
Your Deduction	\$92.31

The Primary Care Provider ID is AA2312422. You have seen this provider before.

Your Covered Dependents

Dependent Information

Name	Relationship	Select a Provider	Existing Patient
Martha Jefferson	Spouse	AA2312422	<input checked="" type="checkbox"/>

Notes

Once submitted, this choice will take effect on 03/18/2018. Deductions for this choice will start with the pay period containing 04/01/2018.

Select the **Update Elections** button to store your choices.

Select the **Discard Changes** button to go back and change your choices.

32 Make other Benefit elections as above; and once completed, click on Submit.

Enrollment Elections Summary

Edit	Medical	Full Cost	Lahey Paid	Before Tax Deduction	After Tax Deduction
	Current: No Coverage				
	New: HP- Lahey Health Preferred HMO:Ind+Spouse	849.74	757.43	92.31	0.00
<input type="button" value="Edit"/>	Dental				
	Current: No Coverage				
	New: Waive	0.00	0.00		
<input type="button" value="Edit"/>	Vision				
	Current: No Coverage				
	New: Waive	0.00	0.00		
<input type="button" value="Edit"/>	Health Care FSA				
	Current: No Coverage				
	New: Waive	0.00	0.00	0.00	
<input type="button" value="Edit"/>	Dependent Care FSA				
	Current: No Coverage				
	New: Waive	0.00	0.00	0.00	
<input type="button" value="Edit"/>	Basic Life				
	Current: No Coverage				
	New: BLF 1X: Salary X 1 : \$125,000	2.02	2.02		
<input type="button" value="Edit"/>	Supplemental Life				
	Current: No Coverage				
	New: Waive	0.00	0.00		
<input type="button" value="Edit"/>	Accidental Death/Dismemberment				
	Current: No Coverage				
	New: Waive	0.00	0.00		

<input type="button" value="Edit"/>	Accidental Death/Dismemberment				
	Current: No Coverage				
	New: Waive	0.00	0.00		
<input type="button" value="Edit"/>	Child Life				
	Current: No Coverage				
	New: Waive	0.00	0.00		
<input type="button" value="Edit"/>	Spousal Life				
	Current: No Coverage				
	New: Waive	0.00	0.00		
<input type="button" value="Edit"/>	Basic Long Term Disability				
	Current: No Coverage				
	New: Basic LTD 60% of Eligible Pay: 60.00% of Salary	34.94	34.94		
<input type="button" value="Edit"/>	Legal Plan				
	Current: Waive				
	New: Waive	0.00	0.00		
<input type="button" value="Edit"/>	Employee Assistance Program				
	Current: Employee Assistance Plan				
	New: Employee Assistance Plan	0.00	0.00		
<input type="button" value="Edit"/>	Buy-Up Long Term Disability				
	Current: No Coverage				
	New: No Coverage				

This table summarizes estimated costs for your new benefit choices. (The "Employer" column displays the amount that Lahey Health is contributing to subsidize the cost of your benefits.)

	Before Tax Deduction	After Tax Deduction	Total
Full Cost			886.70
Lahey Paid			-794.39
Your Deduction	92.31	0.00	92.31

Some of these costs are based on your regularly scheduled hours and pay rate. These costs may change if your regularly scheduled hours or pay rate change.

Select your Lahey Health benefits, then click **Submit** to send your final choices through Colleague Connection.

i Important: Your enrollment will not be complete until you submit your choices through Colleague Connection.



Note: You can add additional accounts by clicking on Add Accounts

Direct Deposit
Yogi Bear

Review, add or update your direct deposit information.

Direct Deposit Details

Account Type	Routing Number	Account Number	Deposit Type	Amount or Deposit Order	Edit	Remove
Checking	2	1	Percent	100.00% 1		

Add Account (38)

39 Click **Tax Withholding**.

Attachments
Personal Details
Benefits
Payroll
Direct Deposits
Tax Withholding (39)
W2/W2-C Consent
Summary

Company: Lahey Clinic Hospital Inc
Status: Active

Form Type	Jurisdiction	Tax Status	Married	Withholding Allowances
Federal	Federal	Additional Amount	0:00	Additional Allowances
		Additional Percentage		Other

40 Click on the **right facing arrow** for Federal.

Attachments
Personal Details
Benefits
Payroll
Direct Deposits
Tax Withholding (40)
W2/W2-C Consent
Summary

Company: Lahey Clinic Hospital Inc
Status: Active

Form Type	Jurisdiction	Tax Status	Married	Withholding Allowances
Federal	Federal	Additional Amount	0:00	Additional Allowances
		Additional Percentage		Other
State	Massachusetts	Additional Amount	0:00	Additional Allowances
		Additional Percentage		Other

41 Click on the **right facing arrow** for Federal.

Federal Tax Withholding Forms

Company: Lahey Health Shared Services

You must complete Form W-4 so the Payroll Department can calculate the correct amount of tax to withhold from your pay. Federal income tax is withheld from your wages based on marital status and the number of allowances claimed on this form. You may also specify that an additional dollar amount be withheld. You can file a new Form W-4 anytime your tax situation changes and you choose to have more, or less, tax withheld.

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

You can make changes to your withholding allowances online using the downloaded updateable PDF form and submit the changes for processing by your payroll department. Be sure to print or save a copy of the completed form for your records.

Updateable Forms
Form Description
Federal Withholding Allowance Certificate (41)

42 Click on **OK**.

WARNING

The system will download to your computer a copy of the tax form which contains personal information. You should not continue if you are using a shared computer. You should not continue if you are using a trusted and secure computer. (such as those in a library or internet cafe), doing this could leave your personal information vulnerable

OK (42) Cancel

43 Click on the **download icon**. The form will download and you will see a pdf icon on the bottom of your screen.

Employees Self Service
Tax Withholding
Company: Lahey Health Shared Services
Status: Active
Form Type: Federal
State: Massachusetts

Company: Lahey Health Shared Services

You must complete Form W-4 so the Payroll Department can calculate the correct amount of tax to withhold from your pay. Federal income tax is withheld from your wages based on marital status and the number of allowances claimed on this form. You may also specify that an additional dollar amount be withheld. You can file a new Form W-4 anytime your tax situation changes and you choose to have more, or less, tax withheld.

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

You can make changes to your withholding allowances online using the downloaded updateable PDF form and submit the changes for processing by your payroll department. Be sure to print or save a copy of the completed form for your records.

Updateable Forms
Form Description
Federal Withholding Allowance Certificate

43
PYTW_HJDE.pdf

Note: depending on the browser that you are using the download may show up differently.

44 Enter the withholding information in lines 3, 5, and 6 and click on Submit.

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

W-4 Employee's Withholding Allowance Certificate
Form 1040-R
Department of the Treasury Internal Revenue Service
OMB No. 1545-0074
2017

1 Your first name and middle initial: Louie Smith
2 Your social security number: XXX-XX-1111

3 Single Married Married, but withheld at higher Single rate.
Home address (number and street or rural route): 1545 North West St.
City or town, state, and ZIP code: Boston, MA 06111

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 2017, 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 Not Applicable

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.): Louie Smith Date: 05/07/2018
8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS): Lahey Health Shared Services 41 Mall Road Burlington, MA 01805
9 Office code (optional): 43178972
10 Employer identification number (EIN): 43178972
For Privacy Act and Paperwork Reduction Act Notice, see page 2. Cat. No. 10220Q Form W-4 (2017) (44)
Submit

45 Enter your **User name** and **Password** and click on OK.

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

W-4 Windows Security
Department of the Treasury Internal Revenue Service
OMB No. 1545-0074
2017

The server uvpsphapt02gl.lahey.health.org is asking for your user name and password. The server reports that it is from PeopleSoft Enterprise PeopleTools.

Warning: Your user name and password will be sent using basic authentication on a connection that isn't secure.

User name
Password
 Remember my credentials

OK (45) Cancel
Submit

46 Click on the **right facing arrow** for State.

Attachments
Personal Details
Benefits
Payroll
Direct Deposits
Tax Withholding (46)
W2/W2-C Consent
Summary

Company: Lahey Clinic Hospital Inc
Status: Active

Form Type	Jurisdiction	Tax Status	Married	Withholding Allowances
Federal	Federal	Additional Amount	0:00	Additional Allowances
		Additional Percentage		Other
State	Massachusetts	Additional Amount	0:00	Additional Allowances
		Additional Percentage		Other



47 Click on the right facing arrow for **Updatable Forms**.

State Tax Withholding Forms

Company Lahey Health Shared Services

You may complete Massachusetts Form M-4 so the Payroll Department can calculate the correct amount of tax to withhold from your pay. Massachusetts income tax is withheld from your wages based on what you claim on the Massachusetts Employee's Withholding Exemption Certificate (form M-4). You can file a new M-4 form anytime your tax situation changes.

Whether you are entitled to claim a certain number of exemptions from withholding is subject to review by the State. Your employer may be required to send a copy of this form to the Agency.

You can make changes to your withholding allowances online using the downloaded updatable PDF form and submit the changes for processing by your payroll department. Be sure to print or save a copy of the completed form for your records.

Updateable Forms

Form Description

Massachusetts Withholding Allowance Certificate

48 Click on **OK**.

WARNING

The system will download to your computer a copy of the tax form which contains personal information. You should not use a shared computer or a public computer if you are using a trusted and secure computer (such as those in a library or internet cafe), doing this could leave your personal information vulnerable.

OK **Cancel**

49 Click on the **download icon**. The form will download and you will see a pdf icon on the bottom of your screen.

State Tax Withholding Forms

Company Lahey Health Shared Services

You may complete Massachusetts Form M-4 so the Payroll Department can calculate the correct amount of tax to withhold from your pay. Massachusetts income tax is withheld from your wages based on what you claim on the Massachusetts Employee's Withholding Exemption Certificate (form M-4). You can file a new M-4 form anytime your tax situation changes.

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You can make changes to your withholding allowances online using the downloaded updatable PDF form and submit the changes for processing by your payroll department. Be sure to print or save a copy of the completed form for your records.

Updateable Forms

Form Description

Massachusetts Withholding Allowance Certificate

PTW_M-4 (3).pdf

Note: depending on the browser that you are using the download may show up differently.

50 Enter the **withholding information in lines 1 - 4** and click **Submit**.

FORM M-4 MASSACHUSETTS EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE Rev. 1/12

Print full name **Louie Smith** Social Security no. **XXX-XX-1111**
 Print home address **1945 North West St.** City **Boston** State **MA** Zip **06111**

HOW TO CLAIM YOUR WITHHOLDING EXEMPTIONS

- Your personal exemption. Write the figure "1." if you are age 65 or over or will be before next year; write "2" if you are under 65.
- If married and if exemption for spouse is allowed, write the figure "X." If your spouse is age 65 or over or will be before next year and if otherwise qualified, write "S." See Instruction C.
- Write the number of your qualified dependents. See Instruction D.
- Add the number of exemptions which you have claimed above and write the total.

Additional withholding per pay period under agreement with employer \$ _____

A. Check if you will file as head of household on your tax return.
 B. Check if you are blind. C. Check if spouse is blind and not subject to withholding.
 D. Check if you are a full-time student engaged in seasonal, part-time or temporary employment whose estimated annual income will not exceed \$8,000.

EMPLOYER: DO NOT withhold if Box D is checked.

I certify that the number of withholding exemptions claimed on this certificate does not exceed the number to which I am entitled.

Date **05/08/2018** Signed **Louie Smith**

Submit

Note: You may also need to check one of the boxes for 5 if applicable.

51 Enter your **User name and Password** and click on **OK**.

Windows Security

The server **uvpsapp02gl.laheyhealth.org** is asking for your user name and password. The server reports that it is from **PeopleSoft Enterprise PeopleTools**.

Warning: Your user name and password will be sent using basic authentication on a connection that isn't secure.

User name _____
 Password _____
 Remember my credentials

OK **Cancel** **Submit**

52 After all the steps have been completed you can click on the **Summary** link to review the completion status.

- ▶ **Voluntary Self Identification**
In Progress
- * **Documents**
⚠ Overdue
- Attachments**
○ Visited
- ▶ **Personal Details**
○ Visited
- ▶ **Benefits**
○ Visited
- ▶ **Payroll**
○ Visited
- Summary** (52)
○ Visited

You have successfully completed OnBoarding process steps.