CITY OF JONESBORO

Regular Meeting

170 SOUTH MAIN STREET

September 12, 2016 – 6:00 PM

NOTE: As set forth in the Americans with Disabilities Act of 1990, the City of Jonesboro will assist citizens with special needs given proper notice to participate in any open meetings of the City of Jonesboro. Please contact the City Clerk's Office via telephone (770-478-3800) or email at rclark@jonesboroga.com should you need assistance.

Agenda

I. CALL TO ORDER

II. ROLL CALL

III. INVOCATION

IV. PLEDGE OF ALLEGIANCE

V. ADOPTION OF AGENDA

VI. PUBLIC HEARING

A. Public Hearing regarding Variance #16VAR-002 as requested by Tara Wrecker located at 9140 Turner Road to reduce the land buffer from 150' to 50'.

B. Public Hearing regarding Conditional Use Permit Application #16CU-007 to allow a Professional & Technical Services Training Facility at property located at 184 North Avenue, Suite 105 (YCDI Institute).

C. Public Hearing regarding adoption of the Official City of Jonesboro Zoning Map.

VII. PUBLIC COMMENT

VIII. CONSIDER APPROVAL OF MINUTES OF THE FOLLOWING MEETINGS

A. City Council - Regular Meeting - Jul 11, 2016 6:00 PM

B. City Council - Special Called Meeting - Aug 31, 2016 6:00 PM

IX. CONSENT AGENDA

A. Council to consider Resolution #2016-12 to declare the need for the activation of a Downtown Development Authority to function in the City of Jonesboro.

B. Council to consider proposal with ADP for integrated technology application.

C. Council to consider the appointment of Allen Roark to the Jonesboro Housing Authority to complete the unexpired term of James Henry to expire June 9, 2017.

X. OLD BUSINESS

A. Council to consider Conditional Use Permit Application #16CU-007 to allow a Professional & Technical Services Training Facility at property located at 184 North Avenue, Suite 105. (YCDI Institute)

B. Council to consider Variance #16VAR-002 as requested by Tara Wrecker located at 9140 Turner Road to reduce the land buffer from 150' to 50'.

C. Council to consider adoption of the Official Zoning Map, as required by Section 86-74 of the Jonesboro Code of Ordinance.

XI. NEW BUSINESS

XII. REPORT/ANNOUNCEMENT FROM MAYOR/CITY CLERK

XIII. REPORT OF COUNCILMEMBERS

XIV. OTHER BUSINESS

XV. ADJOURNMENT

CITY OF JONESBORO
REGULAR MEETING
170 SOUTH MAIN STREET
July 11, 2016 – 6:00 PM

MINUTES

The City of Jonesboro Mayor & Council held their Regular Meeting on Monday, July 11, 2016. The meeting was held at 6:00 PM at the Jonesboro Police Station, 170 South Main Street, Jonesboro, Georgia.

I. CALL TO ORDER - MAYOR JOY B. DAY

II. ROLL CALL - RICKY L .CLARK, JR., CITY ADMINISTRATOR

Attendee Name	Title	Status	Arrived
Joy B. Day	Mayor	Present	
Jack Bruce	Councilmember	Present	
Pat Sebo	Councilmember	Present	
Billy Powell	Councilmember	Present	
Larry Boak	Councilmember	Present	
Ed Wise	Councilmember	Present	
Ricky Clark	City Administrator	Present	
Joe Nettleton	Director of Public Works	Present	

III. ADOPTION OF AGENDA

1. Motion to amend the Agenda by adding as Item D Under New Business: Council to consider Resolution #2016-11 to call and authorize a Special Election to fill the unexpired term of Councilman Wallace Norrington, to fix and publish the qualifying fee; and for other purposes.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Pat Sebo, Councilmember
SECONDER:	Ed Wise, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

2. Motion to adopt agenda as amended.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Pat Sebo, Councilmember
SECONDER:	Ed Wise, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

IV. INVOCATION - LED BY COUNCILWOMAN SEBO

V. PLEDGE OF ALLEGIANCE

VI. PRESENTATIONS - NONE

VII. PUBLIC HEARING

A. Public Hearing regarding variance requests by CVS at property located at 8139 Tara Blvd. Jonesboro, Georgia 30236.

At this time, Mayor Day opened the Public Hearing for the aforementioned item.
As none were present to speak, the Public Hearing was duly adjourned.

B. Public Hearing regarding Conditional Use Permit No. 16CU-006 to allow a chilcare center at 118 Stockbridge Road as requested by Ms. Pam's Precious Angels Family Childcare Center

At this time, Mayor Day opened the Public Hearing for the aforementioned item.
As none were present to speak, the Public Hearing was duly adjourned.

C. BREAKING DOWN BARRIERS MINISTRY ATLANTA

As no one was present to speak, the Public Hearing was duly adjourned.

VIII. PUBLIC COMMENT- (PLEASE LIMIT COMMENTS TO THREE (3) MINUTES)

Mr. David Barron (no address indicated) - Requested a status update of finalization of Streetscape Phase II.

IX. CONSIDER APPROVAL OF MINUTES OF THE FOLLOWING MEETINGS

A. City Council - Regular Meeting - Jun 13, 2016 6:00 PM

RESULT:	**ACCEPTED [UNANIMOUS]**
MOVER:	Jack Bruce, Councilmember
SECONDER:	Larry Boak, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

B. City Council - Work Session - Jul 5, 2016 6:00 PM

RESULT:	**ACCEPTED [UNANIMOUS]**
MOVER:	Ed Wise, Councilmember
SECONDER:	Pat Sebo, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

X. CONSENT AGENDA

RESULT:	**ADOPTED [UNANIMOUS]**
MOVER:	Billy Powell, Councilmember
SECONDER:	Jack Bruce, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

A. Council to consider purchase of a 2011 Ford F-750 with 13 YD NewWay Viper, Winch & Cart Tipper.

B. Council to consider FY' 16 Budget Amendments #16-03 & #16-04 totaling $113,936.00.

XI. OLD BUSINESS

A. Council to consider Conditional Use Permit No. 16CU-005 at 231 Stockbridge Road as requested by Breaking Down Barriers Ministry to allow for a "Place of Worship."

RESULT:	**DENIED [4 TO 1]**
MOVER:	Ed Wise, Councilmember
SECONDER:	Billy Powell, Councilmember
AYES:	Pat Sebo, Billy Powell, Larry Boak, Ed Wise
NAYS:	Jack Bruce

B. Council to consider Conditional Use Permit #16CU-006 to allow a childcare center (Ms. Pam's Precious Angels Family Childcare Center) at property located at 118 Stockbridge Road by Tamarra Johnson.

RESULT:	**DENIED [UNANIMOUS]**
MOVER:	Billy Powell, Councilmember
SECONDER:	Pat Sebo, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

C. Council to consider various variances at property located at 8139 Tara Boulevard as requested by CVS.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Billy Powell, Councilmember
SECONDER:	Ed Wise, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

XII. NEW BUSINESS

A. Council to consider Ordinance #2016-08 establishing a moratorium on the acceptance of any occupational tax certificate application, zoning application, application for sign permits, use permits or other applications relating to the sale or maintenance services of new or used automobiles.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Pat Sebo, Councilmember
SECONDER:	Billy Powell, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

120 Days.

B. Council to consider approval of Application 16ALCSUB-003, as submitted by Savoy Bar and Grill, requesting an alcohol sub-permit for Lee Street Park on July 30, 2016.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Billy Powell, Councilmember
SECONDER:	Pat Sebo, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

C. Council to confirm appointment of Councilman Billy Powell to the City of Jonesboro Accident Review Committee.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Ed Wise, Councilmember
SECONDER:	Larry Boak, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

D. Council to consider Resolution #2016-11 to call and authorize a Special Election to fill the unexpired term of Councilman Wallace Norrington, to fix and publish the qualifying fee; and for other purposes.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Pat Sebo, Councilmember
SECONDER:	Ed Wise, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

XIII. REPORT/ANNOUNCEMENT FROM MAYOR/CITY CLERK

- Clayton County Police Department will hold a "Stand Together in Prayer for Our Community" event on Wednesday, July 13th beginning at 7:00 p.m. at the New Macedonia Baptist Church in Riverdale. All are invited to attend.
- Park Ranger Update - One officer has been hired by the name of Scott Callaway. He will be working evening hours patrolling Lee Street Park, Massengale Park & Battleground Park.
- Screen on the Green Event - Friday, July 22, 2016. The Vineyard Band will open at 8:00 p.m. The film, American Anthem, will be shown.
- Tailgate Party - Spend an evening in Lee Street Park recognizing local sports heroes including D.J. Shockley & other special guests. We will celebrate athletes of all ages, cheerleaders, bands, booster clubs, field games and much more.
- LCI - We have officially kicked off our preliminary meetings for the recently approved LCI update. An email was distributed earlier requesting that each Councilmember put forth two names of individuals in which they would like to see serve on the steering committee.

XIV. REPORT OF COUNCILMEMBERS - NONE

XV. OTHER BUSINESS - NONE

XVI. ADJOURNMENT

A. Motion to adjourn.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Billy Powell, Councilmember
SECONDER:	Pat Sebo, Councilmember
AYES:	Bruce, Sebo, Powell, Boak, Wise

JOY B. DAY – MAYOR

RICKY L. CLARK, JR. – CITY ADMINISTRATOR

CITY OF JONESBORO
SPECIAL CALLED MEETING
170 SOUTH MAIN STREET
August 31, 2016 – 6:00 PM

MINUTES

The City of Jonesboro Mayor & Council held their Special Called Meeting on Wednesday, August 31, 2016. The meeting was held at 6:00 PM at the Jonesboro Police Station, 170 South Main Street, Jonesboro, Georgia.

I. CALL TO ORDER

Attendee Name	Title	Status	Arrived
Joy B. Day	Mayor	Present	
Jack Bruce	Councilmember	Present	
Pat Sebo	Councilmember	Present	
Billy Powell	Councilmember	Present	
Larry Boak	Councilmember	Present	
Ed Wise	Councilmember	Present	
Ricky Clark	City Administrator	Present	
Joe Nettleton	Director of Public Works	Present	

II. AGENDA ITEMS

1. Discussion regarding sanitation collection services.

RESULT: **NO ACTION TAKEN**

Recommendation from City Council for Staff to request information regarding cost of dumping at other landfill sites. Further, Council requested that a Public Hearing be held to allow time for citizen input.

III. ADJOURNMENT

1. Motion to adjourn.

RESULT: **APPROVED [UNANIMOUS]**
MOVER: Ed Wise, Councilmember
SECONDER: Pat Sebo, Councilmember
AYES: Bruce, Sebo, Powell, Boak, Wise

JOY B. DAY – MAYOR

RICKY L. CLARK, JR. – CITY ADMINISTRATOR

CITY OF JONESBORO, GEORGIA COUNCIL

Agenda Item Summary

Agenda Item # – A

COUNCIL MEETING DATE
September 12, 2016

Requesting Agency (Initiator)	**Sponsor(s)**
Office of the City Administrator	

Requested Action *(Identify appropriate Action or Motion, purpose, cost, timeframe, etc.)*
Council to consider Resolution #2016-12 to declare the need for the activation of a Downtown Development Authority to function in the City of Jonesboro.

Requirement for Board Action *(Cite specific Council policy, statute or code requirement)*
Article IX, Section VI, Paragraph III of the GA Constitution

Is this Item Goal Related? *(If yes, describe how this action meets the specific Board Focus Area or Goal)*
Yes Economic Development

Summary & Background *(First sentence includes Agency recommendation. Provide an executive summary of the action that gives an overview of the relevant details for the item.)*

As you are aware, over the last couple of months the Mayor& I have worked with the company interested in purchasing and rehabbing Keystone Apartments, the Hampstead Group. As part of the deal to rehab Keystone, the Hampstead company was seeking to receive a tax exempt bond from the Clayton County Housing Authority by way of the Board of Commissioners. Some of you may ask, "What is a tax exempt bond?" State and local governments around the country issue a large quantity of debt securities to raise needed capital. The majority of these securities—often referred to as municipal **bonds** or simply "munis"—provide investors with interest that is **exempt** from federal income **taxes**. When you think of the revenue saved from issuance of a tax exempt bond, it is well worth the effort by the developer.

When this item was introduced to the County Commission, they voted 4-1 to deny the tax exempt bond deal. Bear in mind, this is a privately issued bond so there is no financial responsibility of the County. If the bond holder defaults for some reason, it doesn't place the County at any risk for paying back the debt of the bond. Recently there were two other similar, yet far different bond proposals that went before the county commission and were also turned down.

After hearing the news of the denial, I immediately kicked in to action to formulate a contingency plan to salvage the deal. After substantial research and discussion amongst staff, our legal team & the Hampstead Group, ironed out three potential options to ensure the deal moved forward and that Keystone received the rehabilitation that it needs. Those potential solutions include the following:

1. Re-introduce the item to the Clayton County Commission on 09/06 after clearing the air with several of the commissioners and securing enough votes to pass;
2. "Activate" the Jonesboro Housing Authority to be able to issue the bonds

FOLLOW-UP APPROVAL ACTION (City Clerk)

Typed Name and Title	**Date**		
Ricky Clark, City Administrator	September, 12, 2016	09/06/16 ITEM	City Council Next: 09/12/16 CONSENT AGENDA
Signature	**City Clerk's Office**		

3. Create a new Jonesboro Downtown Development Authority (DDA) has the authority to issue tax exempt bonds.

It is my recommendation that we, (City Council), create the DDA, appoint members and let this entity issue the tax exempt bond. Should the creation of the DDA pass, the DDA would stand to gain at least $30,000.00 the first year and 0.125% of the total construction cost for a total of 10 years for debt service. This would allow the DDA to be established, and to have a revenue source to begin putting financial incentives in to place for our Downtown District.

Continued…

Creation of DDA

Downtown development authorities are used in cities throughout the state as a mechanism to revitalize and redevelop municipal central business districts. Downtown development authorities have been created by the General Assembly in every city in the state of Georgia. However, downtown development authorities cannot transact any business or exercise any powers until activated by adopting and filing an ordinance or resolution. The resolution must declare the need for the authority, specify the boundaries of the downtown development area that constitutes the central business district and appoint the initial directors.

What powers does a DDA have?

OCGA 36-42-8 lists the general powers of downtown development authorities. As with other types of authorities in Georgia, downtown development authorities may accept grants and apply for loans. They can also own, acquire and improve property, and they are empowered to enter into contracts and intergovernmental agreements. DDAs also have the authority to issue revenue bonds.

How many members serve on a DDA board?

A DDA consists of a board of seven directors who are appointed by the municipal governing authority to serve staggered four-year terms. Directors are appointed by the governing body and must be taxpayers who live in the city or they must own or operate a business located within the downtown development area. They must also be taxpayers who live in the county in which the city is located. One of the directors can be a member of the municipal governing authority. Board members do not receive any compensation for serving on the DDA, except for reimbursement for actual expenses incurred in performing their duties. At this time we are requesting that the following members be confirmed:

1. Allen Roark
2. Joel Aviles
3. Donya Sartor
4. Harry Osborne
5. Helen Meadows
6. Juli Segner

7. Joy B. Day, M

Fiscal Impact *(Include projected cost, approved budget amount and account number, source of funds, and any future funding requirements.)*

N/A

Exhibits Attached (Provide copies of originals, number exhibits consecutively, and label all exhibits in the upper right corner.)

- DDA Boundary Map 083016

Staff Recommendation *(Type Name, Title, Agency and Phone)*

Approval

W I T N E S S E T H:

WHEREAS, the City Council of The City of Jonesboro, Georgia (the "Governing Body") is the governing authority of The City of Jonesboro, Georgia (the "City"), a municipal corporation created and existing under the laws of the State of Georgia, and is charged with the duty of managing the affairs of the City; and

WHEREAS, it has been determined by the Governing Body that there exists an urgent need for the revitalization and redevelopment of the central business district of the City, in order to develop and promote for the public good and general welfare trade, commerce, industry, and employment opportunities in the City and to promote the general welfare of the State of Georgia, by creating a climate favorable to the location of new industry, trade, and commerce and the development of existing industry, trade, and commerce within the City; and

WHEREAS, Article IX, Section VI, Paragraph III of the Constitution of the State of Georgia, which permits the General Assembly of the State of Georgia to create development authorities for certain purposes, and an act of the General Assembly of the State of Georgia entitled the "Downtown Development Authorities Law," as amended, and codified as Chapter 42 of Title 36 of the Official Code of Georgia Annotated (the "Downtown Development Authorities Law"), which was enacted by the General Assembly of the State of Georgia pursuant to authority granted in such constitutional provision, creates in each municipal corporation in the State of Georgia a downtown development authority and authorizes each such municipal corporation to activate a development authority within each such municipal corporation; and

WHEREAS, the Governing Body, after thorough investigation, has determined that it is desirable and necessary that the Downtown Development Authority of the City of Jonesboro, Georgia be activated immediately, pursuant to the downtown Development Authorities Law, in order to fulfill the present needs expressed herein;

NOW, THEREFORE, BE IT RESOLVED by the City Council of The City of Jonesboro, Georgia, and it is hereby resolved by the authority of the same, that there be and there is hereby determined and declared to be a pressing, existing, and future need for a downtown development authority (as more fully described and defined in the Downtown Development Authorities Law) to function in the City for the purpose of revitalizing and redeveloping the central business district of the City in order to develop and promote for the public good and general welfare trade, commerce, industry, and employment opportunities in the City and to promote the general welfare of the State of Georgia, by creating a climate favorable to the location of new industry, trade, and commerce and the development of existing industry, trade, and commerce within the City.

BE IT FURTHER RESOLVED by the aforesaid authority that there be and there is hereby activated in the City the public body corporate and politic known as the "Downtown Development Authority of the City of Jonesboro, Georgia," which was created upon the adoption and approval of the Downtown Development Authorities Law.

BE IT FURTHER RESOLVED by the aforesaid authority that there be and there are hereby appointed as members of the first Board of Directors of the Downtown Development Authority of the City of Jonesboro, Georgia the following named persons, each of whom is a taxpayer residing in the City or is an owner or operator of a business located within the hereinafter defined downtown development area and is a taxpayer residing in Clayton County, Georgia and not more than one of whom is a member of the Governing Body, and

not less than four of whom either have or represent a party who has an economic interest in the redevelo and revitalization of the downtown development area.

Name	Initial Term of Office
Juli Segner	2 years
Helen Meadows	2 years
Allen Roark	4 years
Joy Brantley Day	Ex Officio
Harry Osborne	4 years
Donya Sartor	4 years
Joel Aviles	4 years

BE IT FURTHER RESOLVED by the aforesaid authority that commencing with the date of adoption of this resolution by the Governing Body each of such persons named as directors above shall serve in such capacity for the number of years set forth opposite their respective names, unless they cease to be eligible prior to the expiration of such term, and at the end of any term of office of any director, or upon becoming ineligible, a successor thereto shall be appointed by the Governing Body. A director whose term of office shall have expired shall continue to hold office until his or her successor shall be so appointed.

BE IT FURTHER RESOLVED by the aforesaid authority that the Board of Directors hereinbefore appointed shall organize itself, carry out its duties and responsibilities, and exercise its powers and prerogatives in accordance with the terms and provisions of the Downtown Development Authorities Law as it now exists and as it might hereafter be amended or modified.

BE IT FURTHER RESOLVED by the aforesaid authority that the "downtown development area" shall be that geographical area described in Exhibit A attached hereto and made a part hereof by reference, which area, in the judgment of the Governing Body, constitutes the "central business district" of the City as contemplated by the Downtown Development Authorities Law.

BE IT FURTHER RESOLVED by the aforesaid authority that the City Clerk of the City shall furnish immediately to the Secretary of State of the State of Georgia and to the Department of Community Affairs of the State of Georgia a certified copy of this resolution in compliance with the mandate set forth in the Downtown Development Authorities Law.

BE IT FURTHER RESOLVED by the aforesaid authority that the action taken by the Governing Body herein, including the activation of the Downtown Development Authority of the City of Jonesboro, Georgia under the Downtown Development Authorities Law, is not intended to, and shall in no way or to any extent, impair or otherwise affect the existence, purpose, organization, powers, or function of any other development or other authority heretofore created by constitutional amendment or Act of the General Assembly.

BE IT FURTHER RESOLVED by the aforesaid authority that any and all resolutions in conflict with this resolution be and the same are hereby repealed.

BE IT FURTHER RESOLVED by the aforesaid authority that this resolution shall be effective immediately upon its adoption by the Governing Body, and from and after such adoption and approval the Downtown Development Authority of the City of Jonesboro, Georgia shall be deemed to be fully created and activated.

PASSED, ADOPTED, SIGNED, APPROVED, and **EFFECTIVE** this ___ day of September 20

THE CITY OF JONESBORO, GEORGIA

By:_____

Joy Brantley Day, Mayor

_____

Jack Bruce, Councilman

_____

Pat Sebo, Councilwoman

_____

Billy Powell, Councilman

_____

Larry Boak, Councilman

_____

Ed Wise, Councilman

(SEAL)

Attest:

_____

City Clerk

EXHIBIT A

DESCRIPTION OF DOWNTOWN DEVELOPMENT AREA

[Attached]

STATE OF GEORGIA
CLAYTON COUNTY

CITY CLERK'S CERTIFICATE

I, **RICKY L. CLARK, JR.,** City Clerk of The City of Jonesboro, Georgia (the "City"), **DO HEREBY CERTIFY** that the foregoing pages constitute a true and correct copy of a resolution adopted by the City Council of the City at an open public meeting duly called and lawfully assembled at _____ p.m., on the ___ day of September 2016, in connection with the activation of the Downtown Development Authority of the City of Jonesboro, Georgia, the original of such resolution being duly recorded in the Minute Book of the City, which Minute Book is in my custody and control.

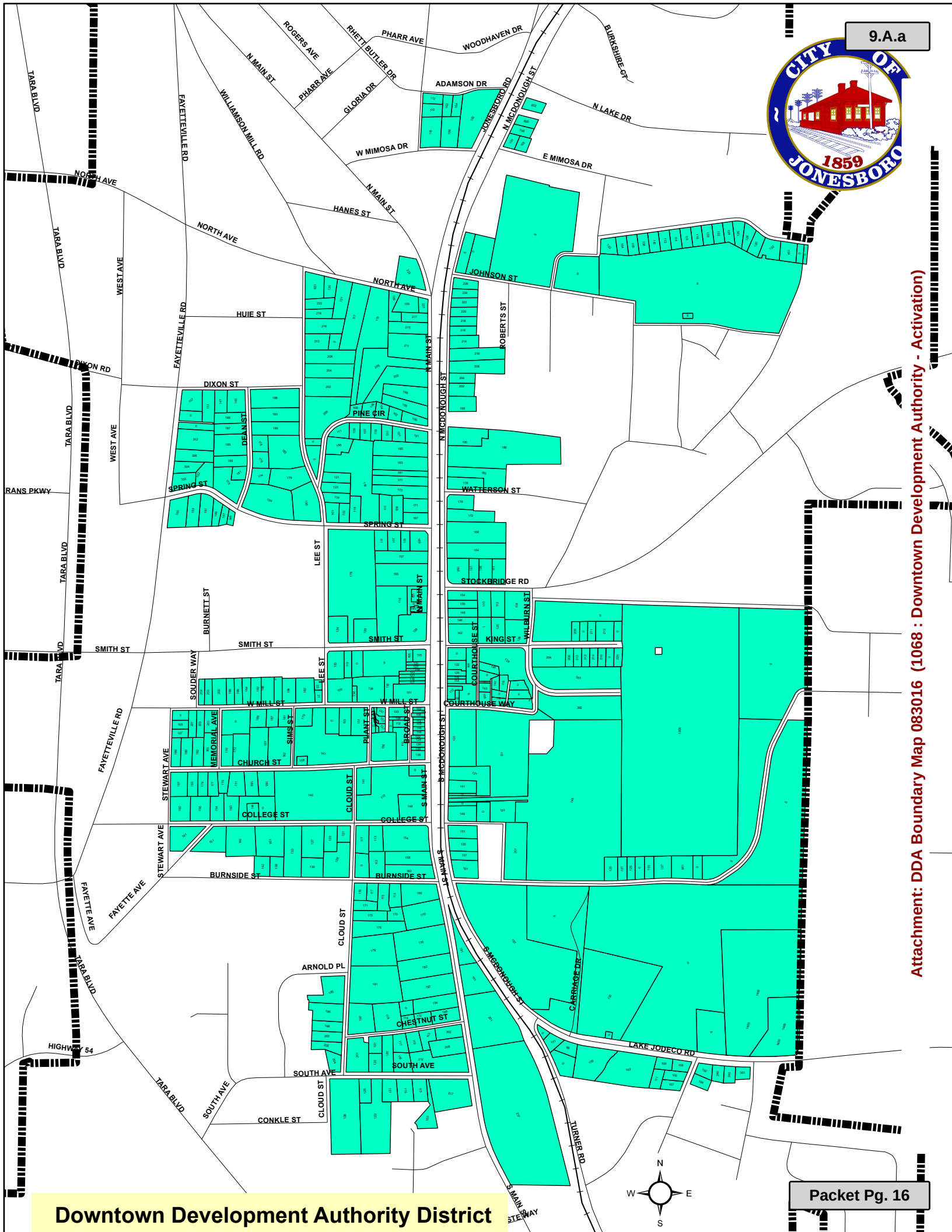
I do hereby further certify that a certified copy of the resolution has been furnished to the Secretary of State of the State of Georgia and the Department of Community Affairs of the State of Georgia as required by the Downtown Development Authorities Law.

WITNESS my hand and the official seal of the City, this the ___ day of September 2016.

(SEAL)

_____

City Clerk, The City of Jonesboro, Georgia



Attachment: DDA Boundary Map 083016 (1068 : Downtown Development Authority - Activation)

Downtown Development Authority District

CITY OF JONESBORO, GEORGIA COUNCIL
Agenda Item Summary

Agenda Item # 9.B
– B

COUNCIL MEETING DATE
September 12, 2016

Requesting Agency (Initiator)
Office of the City Administrator

Sponsor(s)

Requested Action *(Identify appropriate Action or Motion, purpose, cost, timeframe, etc.)*
Council to consider proposal with ADP for integrated technology application.

Requirement for Board Action *(Cite specific Council policy, statute or code requirement)*

Is this Item Goal Related? *(If yes, describe how this action meets the specific Board Focus Area or Goal)*
Yes Innovative Leadership

Summary & Background *(First sentence includes Agency recommendation. Provide an executive summary of the action that gives an overview of the relevant details for the item.)*

Under the Affordable Care Act (ACA), all large employers are required to offer full-time employees affordable health care or fact "assessable payments" or penalties. A large employer is defined as an employer with more than 50 employees. "Full-time" employees are defined as employees working 30 or more hours per week during a month. The City offers affordable health care coverage under the current definition to all of its regular full-time employees.

The Affordable Care Act (ACA) has transformed what was once a benefits-centric annual enrollment event into a monthly process of tracking and reporting extensive data points for every worker across multiple, disparate systems. As a result of (ACA), the rules of workforce management have changed. We now face additional compliance risks, increased complexity and potential confusion about who needs to do what, and when. The ACA is a very complicated law and still subject to interpretation by employers and by the departments administering the law. As a public entity, it is important that the City be in compliance with the law. To that end, staff is requesting that we enhance our program with ADP, our current payroll company.

ADP Health Compliance provides employers with a solution that helps manage crucial employer-related elements of Health Care Reform, including determining ACA offer of coverage eligibility, assessing affordability, and providing a critical Regulatory Management solution that helps us identify and address compliance issues that may result before they become a problem.

Additional features that this document will provide is the new hire reporting & the employee self-serve module. This product does not include time-clock technology; however, that is another critical component that we must analyze.

Another interesting feature that this product will provide, is the platform for all new-hire orientation to be electronic, as well as open enrollment. When hired with the City of Jonesboro, there is a plethora of different forms that must be completed. This product will allow us to go paperless which will provide a more transparent, efficient & quick enrollment process.

Fiscal Impact *(Include projected cost, approved budget amount and account number, source of funds, and any future funding requirements.)*

Current Annual Investment - $8,226.00 per annum

With added services - $15,926.00 per annum

FOLLOW-UP APPROVAL ACTION (City Clerk)

Typed Name and Title	Date		
Ricky Clark, City Administrator	September, 12, 2016	09/06/16 ITEM	City Council Next: 09/12/16 CONSENT AGENDA
Signature	**City Clerk's Office**		

Implementation (One Time Fee) -$5,000.00

Exhibits Attached (Provide copies of originals, number exhibits consecutively, and label all exhibits in the upper right corner.)

- City Of Jonesboro Chart Comparison Pricing
- Current New Hire Packet
- Investment Summary
- WFN HR Management Fact Sheet

Staff Recommendation *(Type Name, Title, Agency and Phone)*

Approval

CURRENT ADP PAYROLL ONLY INVESTMENT	Technology Only Solution / Adding to your existing Payroll Solution
EnhancedPayroll (Technology)	**Human Resources (Enhanced)**
Tax Filing Service	On-line open enrollment
Wage Garnishment	Essential ACA
One Delivery Location	Compliance Reporting
ADP Portal	Policy Acknowlegement
Paid Time Off Accruals Engine	HR Compliance Library
New Hire Reporting	Employee Development Tracking
2 Mgmt Reports	Custom Fields
EE & Mgr Self Svc.	Dependent & Beneficiary Tracking
Online Pay Statements	COBRA Event Tracking
Group Term Life Calculation	Organization Charting
	Essential Time
	Time Collection
	Scheduling
	Paid Time Off Accruals
	Rule Based Calculation
	Request and Approval Workflows
	PTO Management & Reporting
Current ADP Investment	**Technology Time and HR**
	*** Current Payroll Spend: $8,226.00**
	HR/TLM Technology: $ 8,077.20
	Your Total Annual Investment: $ 15,926.00
	Implementation (One Time Fee): $7,700.00
	Year One Increment Investment (with Implementation): $ 15,777.20
*** Current Investment: $8,226.00**	**Year Two Incremental: $8,077.20**

Attachment: City Of Jonesboro Chart Comparison Pricing (1066 : ADP - Technology Module (ACA))

EMPLOYEE CHECKLIST:

NAME: _____

DATE OF HIRE:

_____

FORM DESCRIPTION	DATE TO EMPLOYEE	DATE TO H.R.	DATE TO FILE/MAIL
Employment Application	_____	_____	_____
Tax Forms:			
W-4	_____	_____	_____
State of GA	_____	_____	_____
Insurance Forms	_____	_____	_____
Employee Info Sheet	_____	_____	_____
Health Insurance Forms	_____	_____	_____
Employee Handbook	_____	_____	_____
Motor Vehicle Policy	In handbook	In handbook	In handbook
Technology Use Policy	"	"	"
Direct Deposit Information	_____	_____	_____
Drug and Alcohol Use Policy	_____	_____	_____
AFLAC Info	_____	_____	_____
Other Insurance Info	_____	_____	_____
Business Card	_____	_____	_____
Personnel Action Req. Form (3rd copy – employee)	_____	_____	_____

Signature page and copy of 2nd page of Employee manual _____ yes _____ no

DATE OF SEPERATION: _____

Resignation Letter _____
Cobra Information _____
Separation Notices _____
Insurance Termination Forms _____
Auto Pay Discontinued _____

CITY OF JONESBORO

PERSONNEL ACTION FORM

(SUBMIT TO PERSONNEL OFFICE)

DATE_____

EFFECTIVE DATE_____

☐ REGULAR ☐ TEMPORARY

☐ PART-TIME ☐ OTHER

NAME:_____
(LAST) (FIRST) (MIDDLE)

ADDRESS:_____
(NO.) (STREET) (APT. #) (CITY) (STATE) (ZIP CODE)

S.S. NO._____ Date of Empl._____ Date of Birth_____

Check here for ☐ Change of name ☐ Or address	PREVIOUS NAME_____ PREVIOUS ADDRESS_____
Employment	DEPARTMENT_____ POSITION TITLE_____ G/S_____ PAY RATE_____ Previously Employed? Yes ☐ No ☐
☐ Rate Change ☐ Transfer ☐ Promotion ☐ Demotion	DEPARTMENT from_____ to_____ POSITION TITLE from_____ to_____ GRADE & STEP from_____ to_____ PAY RATE from_____ to_____ EXPLANATION_____ Releasing Dept. Supervisor's Signature_____ (forward to receiving department for supervisor's approval below)
☐ Leave of Absence ☐ Suspension	DEPARTMENT_____ DATE: from_____ to_____ REASON_____
☐ Resignation ☐ Termination (Attach Documentation)	DEPARTMENT_____ POSITION TITLE_____ PAY RATE_____ Annual Leave Due_____ REASON_____ Did employee give notice?_____ How much?_____ Would you rehire? Yes ☐ No ☐ If no, Explain_____

Employee No._____

Class Code No._____

Race/Sex_____

Exempt Status_____

_____
Department Head / Constitutional Officer Date

_____
Personnel Administrator Date

White - Personnel/Payroll Yellow - Dept. Pink - Employ

COJ 001

Date: _____

EMPLOYEE INFORMATION

NAME_____

ADDRESS _____

Number/Street/Route/Box

_____

City/State/Zip

MAILING ADDRESS IF DIFFERENT FROM ABOVE:

_____

_____

HOME PHONE_____ WORK CELL #_____

EMERGENCY CONTACT: _____

_____

NAME/ADDRESS/PHONE

**Employees are asked to update this information when it changes.

GEORGIA MUNICIPAL ASSOCIATION

FAX TO: 678-651-1036 (Preferred)

MAIL TO: GMEBS Life & Health
Enrollment Processing
PO Box 105377
Atlanta, Georgia 30348

PLEASE USE BLACK INK

Benefit Enrollment Form

Effective Date:

Group Name:

Group Number:

SubGroup:

Coverage applied for: ☐ PPO 90/70 ____ ☐ PPO 80/60 ____ ☐ POS 80/60 ____ ☐ HMO ____% ☐ Dental Only ☐ Life/AD&D ☐ Open Enrollment ☐ ACA Enrollment ☐ Special Enrollment

☐ Part-Time to Full-time

Part-time Date of Hire

Full-time Date of Hire

Notice for HMO enrollees- Benefits are provided ONLY when covered services are provided by an HMO participating provider.

Note: You may obtain a Summary of Benefits and Coverage (SBC), which summarizes important information about the health plan(s) offered by your Employer. The SBC will help you understand the plan(s) and compare your options (if more than one plan option is offered by your Employer).

The SBC is available on the web at: www.gmanet.com/lhforms. A paper copy is also available, free of charge, by calling 1-888-488-4462.

Special Enrollment - Documentation supporting eligibility to enroll outside of initial or open enrollment is required.

Employee

Social Security Number:

Date of Birth:

Marital Status: ☐ Single ☐ Divorced ☑ Married ☐ Widowed

Date of Hire:

Last Name:

First Name:

MI:

Home Address:

City:

State:

Zip Code:

Home Phone:

Sex: ☐ Male ☐ Female

Are you applying for dental? ☐ No ☐ Yes

Employment Status: ☐ Active

Coverage Refused:

☐ Medical ☐ Dental ☐ Life

Spouse

Spouse Last Name:

Spouse First Name:

MI:

Social Security Number:

Date of Birth:

Sex: ☐ Female ☐ Male

Coverage Applied For:
Dental ☐ Yes ☐ No
Medical ☐ Yes ☐ No
Life ☐ Yes ☐ No

Attach documentation supporting eligibility

Please complete page 2 for additional dependents.

GMEBSLH.BEF01 (06/2015)

Group Name:

Social Security Number:

Last Name: First Name: MI:

Please complete the above information

Additional Dependents

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth:

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For:
Dental ☐ Yes ☐ No
Medical ☐ Yes ☐ No
Life ☐ Yes ☐ No

Attach documentation supporting eligibility

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth:

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For:
Dental ☐ Yes ☐ No
Medical ☐ Yes ☐ No
Life ☐ Yes ☐ No

Attach documentation supporting eligibility

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth:

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For:
Dental ☐ Yes ☐ No
Medical ☐ Yes ☐ No
Life ☐ Yes ☐ No

Attach documentation supporting eligibility

Child

Last Name: First Name: MI:

Social Security Number: Date of Birth:

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For:
Dental ☐ Yes ☐ No
Medical ☐ Yes ☐ No
Life ☐ Yes ☐ No

Attach documentation supporting eligibility

Group Name:

Social Security Number:

Last Name:

First Name:

MI:

Please complete the above information

Life Insurance Information

If applying for Life Insurance, please provide the following information:

Annual Salary:

Job Class:

☐ Basic Life/AD&D

☐ Supp. Life/AD&D

☐ STD

Primary Beneficiaries					
	Last Name	First Name	MI	Relationship	Percent
1.					
2.					

Contingent Beneficiaries					
	Last Name	First Name	MI	Relationship	Percent
1.					
2.					

Other Insurance

Please complete this section if you or any dependents will have other medical or dental insurance, including Medicare, after coverage begins.

Name of Insured:	Effective Date:	Policy #	Group #	Contract Type:
			☐ Self ☐ Family	☐ Spouse

Insurance Company:	Address:	City:	State:	Zip:

Self - Are you eligible for Medicare?: ☐ Part A / Effective Date ☐ Part B / Effective Date

Is your spouse eligible for Medicare?: ☐ Part A / Effective Date ☐ Part B / Effective Date

MEDICARE HIC#:

Is Medicare coverage related to end stage renal disease? ☐ Yes ☐ No

SAVE AFFIDAVIT. This application for enrollment in the health plan will not be complete until the employee requesting benefits submits to GMEBS a properly completed affidavit confirming the employee's United States citizenship or otherwise lawful presence in the United States. To confirm an employee's eligibility for benefits, GMEBS will verify the employee's alien registration number (if applicable) through the federal Systematic Alien Verification of Entitlement (SAVE) program or a successor program designated by the United States Department of Homeland Security. Until this verification is made, a properly completed affidavit may be presumed to be proof of the employee's lawful presence for the purpose of receiving health benefits. In the event that SAVE is unable to verify an employee's eligibility for health benefits, the employee's health benefits will be terminated.

Documentation. Attach a copy of marriage certificate if enrolling a spouse or stepchild. Attach a copy of birth certificate if enrolling any child. Attach proof of loss of other coverage if requesting special enrollment. Additional documentation may be required.

Employee Affirmation: I affirm that the information provided in this form and the attached documents are accurate.

EMPLOYEE SIGNATURE: _____ Date: _____

Employer Affirmation: I affirm that the individual listed above meets the requirements for eligibility that are stated in the Employer's applicable Declaration Pages.

EMPLOYER SIGNATURE: _____ Date: _____

Georgia Municipal Employees Benefit System
Affidavit Verifying Applicant's Lawful Immigration Status

As an Applicant for benefits administered by the Georgia Municipal Employees Benefit System (GMEBS), I, **[print Applicant's First, Middle, and Last Name here]:**_____ state the following under oath [check (1), (2) or (3) below]:

(1) _____ I am a United States citizen

(2) _____ I am a legal permanent resident of the United States

(3) _____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency. My alien registration number* issued by the Department of Homeland Security or other federal immigration agency is: _____.

I also hereby verify that I am 18 years of age or older and have provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit. The secure and verifiable document provided with this affidavit can best be classified as: _____. I understand that this affidavit is not complete until I have provided such documentation.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____ (state).

_____
Signature of Applicant:

_____
Date of Signature (Month / Day / Year)

_____
GMEBS Member Employer (please print)

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE

Notary Public
My Commission Expires: _____

*Note: O.C.G.A. § 50-36-1(e)(2) requires that qualified aliens or non-immigrants under the federal Immigration and Nationality Act, Title 8 U.S.C., as amended, provide their alien registration number. If you are a qualified alien but you do not have an alien registration number, you may supply another identifying number, as well as its source (providing government entity), below.

Note to GMEBS Member Employer: This application will not be deemed complete unless a copy of the Applicant's secure and verifiable document, as approved and posted by the Attorney General pursuant to O.C.G.A. § 50-36-2(a)(3), is attached to this affidavit.

GEORGIA MUNICIPAL ASSOCIATION

GEORGIA MUNICIPAL ASSOCIATION EMPLOYEES BENEFIT SYSTEM
201 Pryor Street, SW • Atlanta, Georgia 30303 • 404-688-0472 • Fax 678-686-6289

EMPLOYEE WAIVER OF HEALTH PLAN ENROLLMENT

Section I
(To Be Completed By Employee)

Social Security Number: _____

I (Print Full Name) _____
(Last) (First) (Middle)

hereby certify that I have been given the opportunity to enroll in the group health insurance plan of:

_____
(Employer)

administered by the Georgia Municipal Employees Benefit System (GMEBS) and I have voluntarily chosen to decline enrollment in the plan.

I understand that if I am declining enrollment because of other health insurance coverage, I may in the future be able to enroll myself and/or my eligible dependents in the health insurance program if the other coverage is lost, if I apply for special enrollment within 31 days after the other health insurance coverage ends.

I also understand that if I acquire a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and/or my eligible dependents at that time, provided that I apply for special enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. I also understand that I may be able to enroll myself and/or my eligible dependents during the annual open enrollment period.

The benefits of the health insurance program have been thoroughly explained to me and I understand that this plan is the only plan under which the employer will aid in providing health insurance coverage to me.

Date: _____ 20___ _____
(month) (day) (year) (Signature of Employee)

Section II
(To Be Completed by Employer)

On this date, before me personally, came the person who, to the best of my knowledge and belief, is the person named above and who by the above signature(s) executed the foregoing refusal of participation.

Date _____ 20___ _____
(month) (day) (year) (Signature of Employer)

VISION ONLY

Member Enrollment Change Form

PRINT CLEARLY USING BLACK INK ONLY

Employee social security no.

BlueChoice Healthcare Plan (HMO), Blue Open Access HMO, BlueChoice Option (POS), Blue Open Access POS, Blue Essential (Hospital/Surgical) Open Access HMO, and Blue Essential (Hospital/Surgical) Open Access POS plans offered by Blue Cross Blue Shield Healthcare Plan of Georgia, Inc. (BCBSHP).

BlueChoice PPO, Anthem Lumenos HSA, HRA, HIA and HIA+, Traditional Health Plan, Blue Essential (Hospital/Surgical) PPO, Dental, Vision, and EAP plans offered by Blue Cross and Blue Shield of Georgia, Inc. (BCBSGA).

Life and Disability plans offered by Greater Georgia Life Insurance Company, Inc. (GGL).

Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Blue Cross and Blue Shield of Georgia, Inc., and Greater Georgia Life Insurance Company are independent licensees of the Blue Cross and Blue Shield Association. Life and Disability products underwritten by Greater Georgia Life Insurance Company. ®ANTHEM and Lumenos are registered trademarks of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

EMPLOYER/GROUP USE ONLY

Group name	Group no.	Subsection
City of Jonesboro	A15475	

ANTHEM USE ONLY: LUMENOS PLAN INFORMATION

Case no.	Group no.

Last name	First name	M.I	Effective date of changes below

ADDRESS CHANGE

Employee mailing address (street and P.O. box if applicable)

City	State	ZIP code	County

NAME CHANGE

Last name	First name	M.I

Sex	Birthday
☐ Male ☐ Female	

TYPE OF COVERAGE CHANGE

	Plan no.	Consumer Choice (Additional premium applies)
~~☐ HMO*~~		~~☐ Yes ☐ No~~
~~☐ Open Access HMO~~		~~☐ Yes ☐ No~~
~~☐ Traditional Health~~		~~☐ Yes ☐ No~~
~~☐ Traditional (Indemity)~~		~~☐ Yes ☐ No~~
~~☐ Blue Essential (Hospital/Surgical)~~		~~☐ Yes ☐ No~~
~~☐ PPO~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos PPO HSA Qualfied~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos PPO (HRA)~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos PPO (HIA)~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos PPO (HIA+)~~		~~☐ Yes ☐ No~~

	Plan no.	Consumer Choice (Additional premium applies)
~~☐ POS*~~		~~☐ Yes ☐ No~~
~~☐ Open Access POS~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos Open Access POS (HSA)~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos Open Access POS (HRA)~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos Open Access POS (HIA)~~		~~☐ Yes ☐ No~~
~~☐ Anthem Lumenos Open Access POS (HIA+)~~		~~☐ Yes ☐ No~~
~~Dental~~		
~~Vision~~	Blue View Vision	
~~Life (GGL)~~		
~~STD~~		
~~LTD~~		
~~EAP~~		

~~*If changing coverage to an HMO or POS plan, you must select a primary care physician (PCP) for each covered dependent in the spaces provided below.~~

~~PCP name~~	~~Physician I.D. no.~~	~~Are you applying for Dental Insurance? ☐ Yes ☐ No~~	~~I am an existing patient ☐ Yes ☐ No~~

~~TRANSFER TO ANOTHER GROUP NUMBER~~

~~Group no.~~	~~Sub~~	~~Lumenos case no.~~	~~Lumenos group no.~~	~~Coverage transfer effective date~~

Employee Change Form
For 2-50 Employee Small Groups
Georgia

VISION ONLY

Instructions:

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in blue or black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing bcbsga.com.

Section A: General Information

Employer name	Group no	Employee life class
City of Jonesboro	A15475	

Employee last name	Employee first name	M.I.	Employee Social Security no.* (required)

Section B: Employee Information – Required

Reason for change – Required. Check all that apply.
☐ Address change ☐ Add spouse/Domestic Partner or dependent ☐ Change life classification ☐ Cancel coverage
☐ Name change ☐ Cancel spouse/Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Other: ______

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______
Event date/Requested effective date – Required ______ (MM/DD/YYYY)

Home address – Street and PO Box if applicable	City	State	ZIP code

County	Birthdate (MM/DD/YYYY)	Sex	Marital status
		☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner

Primary phone no.	Secondary phone no.	Email address

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section C: Family Information – Spouse and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain ______
Event date/Requested effective date – Required ______ (MM/DD/YYYY)

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Spouse ☐ Domestic Partner

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does the spouse/Domestic Partner have a different address?
☐ Yes ☐ No If yes, please enter: ______

*Blue Cross and Blue Shield of Georgia is required by the Internal Revenue Service to collect this information.

Employee name	Social Security no.

Section C: Family Information – Continued

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____
Event date/Requested effective date – Required _____ (MM/DD/YYYY)

Dependent last name	First name	M I.	Social Security no.* (required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? _____

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address?
☐ Yes ☐ No If yes, please enter: _____

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____
Event date/Requested effective date – Required _____ (MM/DD/YYYY)

Dependent last name	First name	M I.	Social Security no.* (required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? _____

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address?
☐ Yes ☐ No If yes, please enter: _____

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____
Event date/Requested effective date – Required _____ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? _____

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address?
☐ Yes ☐ No If yes, please enter: _____

*Blue Cross and Blue Shield of Georgia is required by the Internal Revenue Service to collect this information.

Employee name	Social Security no.

Section D: Plan/Type of Coverage

1. Medical Coverage

Enter network name, product plan name and contract code selected:

Network name	Product plan name	Contract code, if known

Note for Health Savings Account (HSA) enrollees:
If you enroll in an HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage

Product plan name	Contract code, if known

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

3. Vision Coverage

☐ I am enrolling in my Employer's vision plan, if any.	Contract code, if known

Member vision coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

4. Life Coverage – if offered by your employer

☐ Life & AD&D
☐ Dependent Life

☐ Optional Supplemental Life – Select one:
☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

☐ Other: _____

Primary Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Section E: Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare?
☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date _____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

Is anyone applying for coverage covered by other health coverage?
☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: / / End: / /
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: / / End: / /

Employee name	Social Security no.

Section F: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Blue Cross and Blue Shield of Georgia (BCBSGa) as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

W-9 Certification Language

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this application I represent that: I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide BCBSGa with information regarding my HSA. I hereby authorize the financial custodian to provide BCBSGa with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide BCBSGa with a written request to revoke my authorization at any time.

Coverage Option: If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, BCBSGa or by another carrier.

Abbreviated Notice of Insurance Information Practices Privacy Act. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

All Data Confidential. O.C.G.A. section 33-39-5, subsection (c) (1 through 4) requires that: 1. Personal information may be collected from persons other than the individual or individuals proposed for coverage; 2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization; 3. A right of access and correction exists with respect to all personal information collected; 4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.

Access to Your Data. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Blue Cross and Blue Shield of Georgia, Inc. or Blue Cross Blue Shield Healthcare Plan of Georgia, Inc., Customer Service Department, Post Office Box 7368, Columbus, Georgia 31908-7368.

Sign Here	Applicant signature	Date (MM/DD/YYYY)
	X	

GEORGIA MUNICIPAL ASSOCIATION EMPLOYEES BENEFIT SYSTEM
201 Pryor Street, SW • Atlanta, Georgia 30303 • 404-688-0472 • Fax 678-686-6289

EMPLOYEE WAIVER OF HEALTH PLAN ENROLLMENT

Section I
(To Be Completed By Employee)

Social Security Number: _____

I (Print Full Name) _____
(Last) (First) (Middle)

hereby certify that I have been given the opportunity to enroll in the group health insurance plan of:

_____
(Employer)

administered by the Georgia Municipal Employees Benefit System (GMEBS) and I have voluntarily chosen to decline enrollment in the plan.

I understand that if I am declining enrollment because of other health insurance coverage, I may in the future be able to enroll myself and/or my eligible dependents in the health insurance program if the other coverage is lost, if I apply for special enrollment within 31 days after the other health insurance coverage ends.

I also understand that if I acquire a new eligible dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and/or my eligible dependents at that time, provided that I apply for special enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. I also understand that I may be able to enroll myself and/or my eligible dependents during the annual open enrollment period.

The benefits of the health insurance program have been thoroughly explained to me and I understand that this plan is the only plan under which the employer will aid in providing health insurance coverage to me.

Date: _____ 20___ _____
(month) (day) (year) (Signature of Employee)

Section II
(To Be Completed by Employer)

On this date, before me personally, came the person who, to the best of my knowledge and belief, is the person named above and who by the above signature(s) executed the foregoing refusal of participation.

Date _____ 20___ _____
(month) (day) (year) (Signature of Employer)

EMPLOYEE APPLICATION

PLEASE COMPLETE IN INK. Read and complete all of this form. If you need more space, attach a separate sheet of paper. Please use 4 digits for years (e.g. 1998, not 98).

Greater Georgia Life Insurance Company
P.O. Box 182361
Columbus, OH 43218-2361
800-851-8544 • 404-682-3255 fax

City of Jonesboro

SECTION A. TO BE COMPLETED BY EMPLOYER/GROUP

Group Number	Division Number	Class	Requested Effective Date
GA2106			

SECTION B. APPLICANT INFORMATION

REASON FOR APPLICATION
❑ New Enrollment ❑ Change of Status ❑ Change of Beneficiary ❑ Exercise Portability Option *(complete Sections B, F & G)*
❑ Change of Coverage ❑ Change of Class ❑ Change of Name/Address ❑ Waive Life Coverages *(complete Section H)*

Social Security Number	Last Name, First Name, MI	Home Telephone Number
		( )

Street Address	City	State/Zip	County	Municipality

Are you actively at work? ❑ Yes ❑ No
If no, state reason:

Are you retired? ❑ Yes ☒ No

Sex ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced

Employer/Group Name	Occupation	Business Telephone	Fax Number	E-Mail Address
		770-478-3775	770-478-3775	

Hours working per week for this employer	Date of hire as Full-time	Current Income	Per: ❑ Hour ❑ Week ❑ Month ❑ Year	Income Reported on: ❑ W-2 ❑ 1099 ❑ Other

EMPLOYEE AND DEPENDENT DETAILS *(Complete all details for individuals applying for coverage; list names of all dependents.)*

Last Name, First Name, MI	Social Security Number	Sex	Date of Birth	Age	Relationship	Height	Weight	State of Birth	Eligible for federal income tax exemption?	Full-Time Student?
Employee		M F			self					
		M F								
		M F								
		M F								
		M F								
		M F								

List address of all dependents if different from the applicant, including temporary address, e.g. college student.
Name/Address: _____
Name/Address: _____
Are you or any dependent currently hospitalized? ❑ Yes ❑ No *If yes, list name and reason:* _____

SECTION C. STATUS CHANGE

Reason for status change: ❑ Marriage ❑ Divorce ❑ Spouse Deceased ❑ Birth/Adoption ❑ Termination of Employment

Date Change Occurred:	❑ Change Coverage Amount
❑ Change Name To:	Current Benefit Amount: $
❑ Change Address To:	Change Benefit Amount to: $
❑ Change of Beneficiary *(complete section D)*	❑ Change Life Class to:

❑ Add/Delete Dependents *(include name and date of birth/adoption)*
❑ Other Change *(explain)*

SECTION D. BENEFICIARY DESIGNATION

Primary Beneficiary: *Name:*_____ *Age:*_____ *Relationship:*_____
*Name:*_____ *Age:*_____ *Relationship:*_____

Contingent Beneficiary: *Name:*_____ *Age:*_____ *Relationship:*_____
*Name:*_____ *Age:*_____ *Relationship:*_____

SECTION E. INSURANCE COVERAGES *(Check all that you are applying for.)*

☑ **Basic Life**
☑ **Basic Accidental Death & Dismemberment (AD&D)**
❑ Optional Life: _____ X earnings or $_____
❑ Optional AD&D: _____ X earnings or $_____
❑ Optional Life: Spouse $_____ Child $_____

❑ **Dependent Life**
❑ Short Term Disability
❑ Long Term Disability
❑ Voluntary Short Term Disability
❑ Other: _____

A-MWL-E (PC) 0207

Coverage is limited to what is selected and offered by the employer.

SECTION F. PORTABILITY *(Complete only if exercising portability option. Attach check with application.)*

Date coverage with Employer terminated: N/A | Payment Mode Requested: ❑ Quarterly ❑ Semi-Annual ❑ Annual

Coverage Transfer Options: *(Minimum employee coverage is the lesser of the amount of coverage in-force or $10,000 and employee coverage is required to transfer any dependent coverage. Dependent coverage may not exceed 50% of employee coverage.)*

Employee	❑ Same	❑ Decrease to: _____	❑ Delete coverage
Spouse	❑ Same	❑ Decrease to: _____	❑ Delete coverage
Children	❑ Same	❑ Decrease to: _____	❑ Delete coverage

SECTION G. AUTHORIZATION *(Read carefully before signing.)*

1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract, subject to change by my written notice to my employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages if necessary for the required premium for the coverage for which I have applied.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I am applying for the coverage selected on this application. If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
5. I understand that Greater Georgia Life Insurance Company reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or recission or cancellation of my coverage(s). This authorization, for purposes of processing this application form, is valid from the date signed for a period of thirty months. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my children and my spouse (if spouse does not sign below), if covered by the Plan. I am acting as their agent and representative.

Employee Signature: _____ *Date:* _____

Spouse Signature: _____ *Date:* _____

SECTION H. WAIVER OF LIFE COVERAGE

I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

N/A *Print Employee Name:* _____ *Social Security Number:* _____

Employee Signature: _____ *Date:* _____

The laws of some states require us to provide you with the following information:

In Indiana and Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

In Kentucky: Any person who knowingly and with intent to defraud any insurance company, or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Aetna Mail Service Order Form

Enter ID number

Prescription Plan Sponsor or Company Name

Mail this form to:

Aetna Rx Home Delivery
P.O. Box 829518
Pembroke Pines, FL 33082-9518

Please use **blue or black ink, capital letters,** and fill in **both sides** of this form.

New Prescriptions - Mail your new prescriptions with this form. Number of **New** prescriptions:

Refills - Order by Web, phone, or write in Rx number(s) below. Number of **Refill** prescriptions:

For Fastest Service, order refills at www.aetnanavigator.com or call toll-free **1-888-RX AETNA (1-888-792-3862)** or TDD (for hearing impaired) at **1-800-823-6373.** Your doctor may fax your prescription(s) to **1-877-270-3317.** Only a doctor may fax a prescription.

A Shipping Address.

Last Name | First Name | MI | Suffix (JR, SR)

Street Name | Apt./Suite #

○ **Use this address for this order only.**

City | State | ZIP Code

Daytime Phone #: - - Evening Phone #: - -

B Refills. To order mail service refills, enter your prescription number(s) here.

1) 2) 3) 4)

5) 6) 7) 8)

Aetna wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for Brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions including drug names, use the "Special Instructions" section of this form.

We may package all of these prescriptions together unless you tell us not to.

Please Note: By submitting this form you verify that the information is correct, that the prescriptions enclosed are for use by eligible participants and authorize the release of all information to the Plan Sponsor, administrator, or underwriter. All communications regarding this account will be directed to the member (employee/retiree). If a spouse or other eligible dependent wishes to direct their communications to an alternate address or telephone number, they may make this request by completing the Confidential Communications Request form provided in the Privacy Notice, or as available on our website.

Please fold here

Please fold here

The Lincoln National Life Insurance Company

A Stock Company Home Office Location: Fort Wayne, Indiana
Group Insurance Service Office: P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

Voluntary Life & Voluntary Dependent Life

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: CTYOFJONES	GROUP POLICY #: 000400001000-14423	Billing Division or Location: 1305818

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) City of Jonesboro			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐Male ☐Female	Marital Status: ☐Married ☐Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly $_____	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy.

TYPE OF COVERAGE			AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Employee Life Insurance	☐Yes	☐No	$	$
Voluntary Spouse Life Insurance	☐Yes	☐No	$	$
Voluntary Dependent Child Benefit	☐Yes	☐No	☐ $2,500 ☐ $5,000 ☐ $10,000	$

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address			City	State Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I apply for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ☐ **NOT ENROLL my dependents in the Program.** I understand that if I apply for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____

Form G-4 (Rev. 1/13)

STATE OF GEORGIA EMPLOYEE'S WITHHOLDING ALLOWANCE CERTIFICATE

1a. YOUR FULL NAME	1b. YOUR SOCIAL SECURITY NUMBER
2a. HOME ADDRESS (Number, Street, or Rural Route)	2b. CITY, STATE AND ZIP CODE

PLEASE READ INSTRUCTIONS ON REVERSE SIDE BEFORE COMPLETING LINES 3 – 8

3. MARITAL STATUS

(If you do not wish to claim an allowance, enter "0" in the brackets beside your marital status.)

A. Single: Enter 0 or 1 .....[ ]

B. Married Filing Joint, both spouses working:
Enter 0 or 1 .....[ ]

C. Married Filing Joint, one spouse working:
Enter 0 or 1 or 2 .....[ ]

D. Married Filing Separate:
Enter 0 or 1 .....[ ]

E. Head of Household:
Enter 0 or 1 .....[ ]

4. DEPENDENT ALLOWANCES [ ]

5. ADDITIONAL ALLOWANCES [ ]
(worksheet below must be completed)

6. ADDITIONAL WITHHOLDING $_____

WORKSHEET FOR CALCULATING ADDITIONAL ALLOWANCES
(Must be completed in order to enter an amount on step 5)

1. COMPLETE THIS LINE ONLY IF USING STANDARD DEDUCTION:
Yourself: ☐ Age 65 or over ☐ Blind
Spouse: ☐ Age 65 or over ☐ Blind Number of boxes checked _____ x 1300.....$_____
2. ADDITIONAL ALLOWANCES FOR DEDUCTIONS:

A. Federal Estimated Itemized Deductions.....$_____

B. Georgia Standard Deduction (enter one): Single/Head of Household $2,300
Each Spouse $1,500 $_____

C. Subtract Line B from Line A.....$_____

D. Allowable Deductions to Federal Adjusted Gross Income .....$_____

E. Add the Amounts on Lines 1, 2C, and 2D .....$_____

F. Estimate of Taxable Income not Subject to Withholding .....$_____

G. Subtract Line F from Line E (if zero or less, stop here).....$_____

H. Divide the Amount on Line G by $3,000. Enter total here and on Line 5 above ..... _____

(This is the maximum number of additional allowances you can claim. If the remainder is over $1,500 round up)

7. LETTER USED (Marital Status A, B, C, D, or E) _____ **TOTAL ALLOWANCES** (Total of Lines 3 - 5) _____
(Employer: The letter indicates the tax tables in the Employer's Tax Guide)

8. EXEMPT: (Do not complete Lines 3 - 7 if claiming exempt) **Read the Line 8 instructions on page 2 before completing this section.**

a) I claim exemption from withholding because I incurred no Georgia income tax liability last year **and** I do not expect to have a Georgia income tax liability this year. **Check here** ☐

b) I certify that I am not subject to Georgia withholding because I meet the conditions set forth under the Servicemembers Civil Relief Act as amended by the Military Spouses Residency Relief Act as provided on page 2. My state of residence is _____ My spouse's (servicemember) state of residence is _____ The states of residence must be the same to be exempt. **Check here** ☐

I certify under penalty of perjury that I am entitled to the number of withholding allowances or the exemption from withholding status claimed on this Form G-4. Also, I authorize my employer to deduct per pay period the additional amount listed above.

Employee's Signature_____ Date _____

Employer: Complete Line 9 and mail entire form only if the employee claims over 14 allowances or exempt from withholding.
If necessary, mail form to: Georgia Department of Revenue, Withholding Tax Unit, P. O. Box 49432, Atlanta, GA 30359.

9. EMPLOYER'S NAME AND ADDRESS:

EMPLOYER'S FEIN:_____

EMPLOYER'S WH#:_____

Do not accept forms claiming additional allowances unless the worksheet has been completed. Do not accept forms claiming exempt if numbers are written on Lines 3 - 7.

Form W-4 (2014)

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 2014 expires February 17, 2015. 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 $1,000 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 2014. 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 (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	F ____
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 $65,000 ($95,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to six eligible children or **less** "2" if you have seven or more eligible children. • If your total income will be between $65,000 and $84,000 ($95,000 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

2014

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 2014, 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)

Employment Eligibility Verification

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

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire 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 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	E-mail Address	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):

☐ A citizen of the United States

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

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

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

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

3-D Barcode
Do Not Write In This Space

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

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

Signature of Preparer or Translator:			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

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 examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

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)*:				

3-D Barcode
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	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		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)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current 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:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

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		
		9. Driver's license issued by a Canadian government authority		8. Employment authorization document issued by the Department of Homeland Security
		For persons under age 18 who are unable to present a document listed above:		
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		10. School record or report card		
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

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

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.

MOTOR VEHICLE USE AUTHORIZATION

DEPARTMENT: _____
TITLE: _____
NAME: _____
_____
ADDRESS: _____
_____

-ASSIGNED VEHICLE INFORMATION:

- **V.I.N:** _____
- **TAG NUMBER:** _____
- **VEHICLE NUMBER:** _____
- **VEHICLE YEAR, MAKE, MODEL AND BODY TYPE:**
  _____
  _____
- **SPECIAL EQUIPMENT:** _____
  _____
  _____

-ASSIGNMENT – FULL TIME OR OVERNIGHT

- **TYPE:** _____

APPROVAL BY DEPARTMENT DIRECTOR:

_____
PRINTED NAME: _____
TITLE: _____
DATE: _____

APPROVAL BY MAYOR:

_____
PRINTED NAME: _____

Employee Direct Deposit Enrollment Form

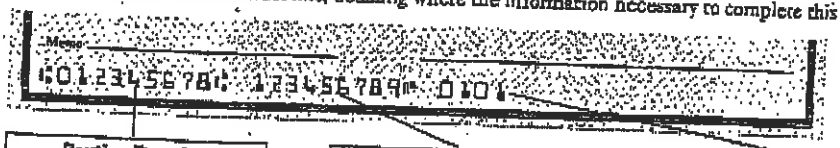
Payroll Manager—Please complete this section and enter data into your ADP Payroll system for employee enrollment. Then contact your CSR or AE for further instructions on how to update your employee's direct deposit information to ADP. NOTE: YOUR COMPANY NAME MUST BE FILLED IN BEFORE DISTRIBUTING THIS FORM TO YOUR EMPLOYEE FOR COMPLETION. (Please print.)

Company Code: _____ Company Name: _____ (referred to herein as "Employer") Employee File Number: _____

Payroll Mgr. Name: _____ Payroll Mgr. Signature: _____

To enroll in Full Service Direct Deposit, simply fill out this form and give it to your payroll manager. Attach a voided check for each checking account – not a deposit slip. If depositing to a savings account, ask your bank to give you the Routing/Transit Number for your account. It isn't always the same as the number on a savings deposit slip. This will help ensure that you are paid correctly.

Below is a sample check MICR line, detailing where the information necessary to complete this form can be found.



Important! Please read and sign before completing and submitting.

I hereby authorize Employer, either directly or through its payroll service provider, to deposit any amounts owed me, by initiating credit entries to my account at the financial institution (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Employer, either directly or through its payroll service provider, to my account. In the event that Employer deposits funds erroneously into my account, I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Employer and Bank have received written notice from me of its termination in such time and in such manner as to afford Employer and Bank reasonable opportunity to act on it.

Employee Name: _____ Social Security #: ___-___-____

Employee Signature: _____ Date: _____

Account Information

The last item must be for the remaining amount owed to you. To distribute to more accounts, please complete another form.

Make sure to indicate what kind of account, along with amount to be deposited, if less than your total net paycheck.

1. Bank Name/City/State: _____

   Routing/Transit #: _____ Account Number: _____

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ ____.__ or ☐ Entire Net Amount

2. Bank Name/City/State: _____

   Routing/Transit #: _____ Account Number: _____

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ ____.__ or ☐ Entire Net Amount

3. Bank Name/City/State: _____

   Routing/Transit #: _____ Account Number: _____

   ☐ Checking ☐ Savings ☐ Other I wish to deposit: $ ____.__ or ☐ Entire Net Amount

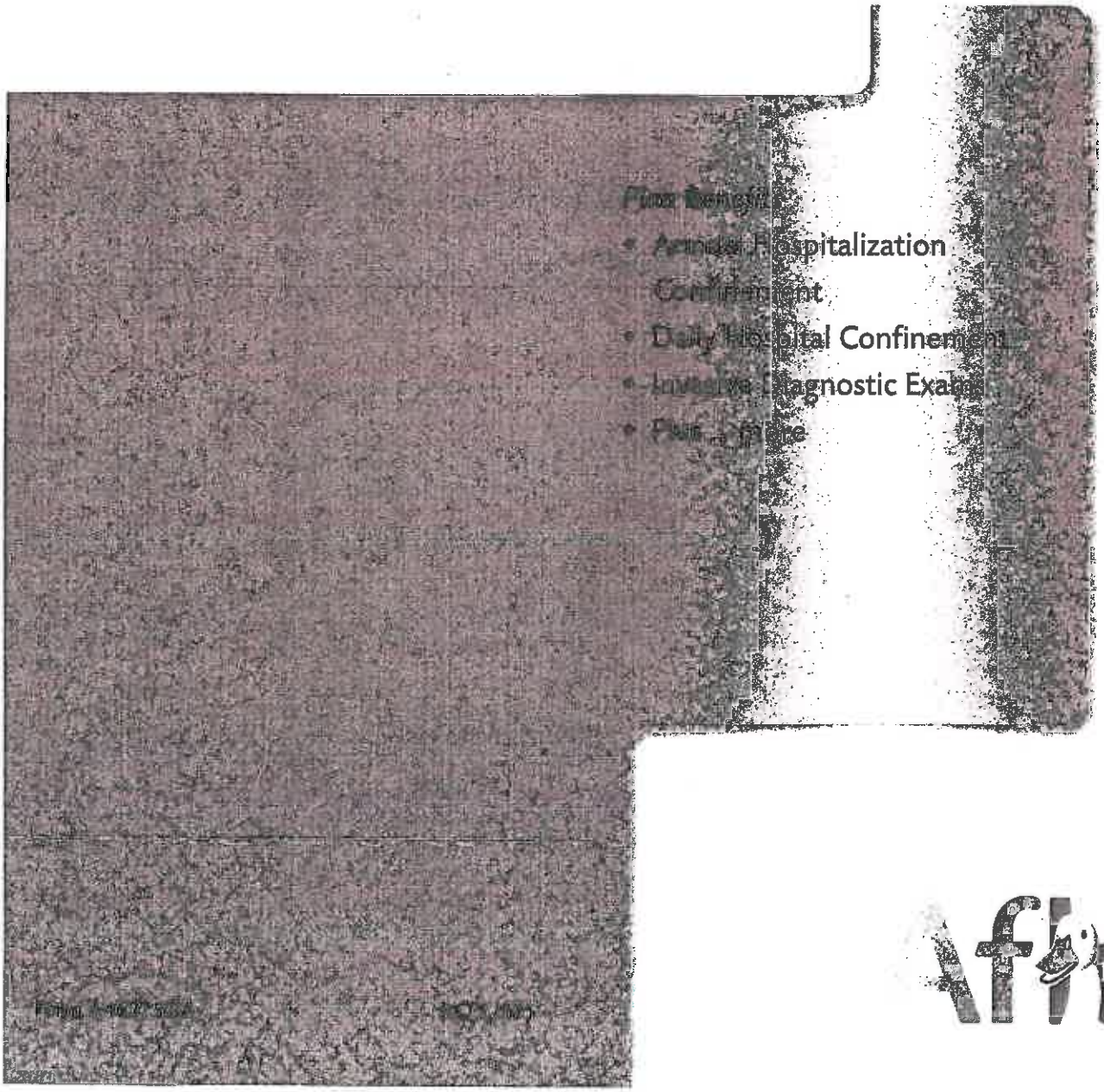
ATTENTION PAYROLL MANAGER:
Employers must keep each original employee enrollment form on file as long as the employee is using FSDD, and for two years thereafter.

Plan 2

Hospital Protection

Hospital Confinement Indemnity Insurance ...

what you need, when you need it.



aflac™

Hospital Protection

Annual Hospitalization Confinement Benefit

Aflac will pay the amount listed below for the first five days of hospitalization when a covered person requires hospital confinement* for a covered sickness or injury and a charge is incurred.

Sickness	*$400 per day*
Injury	*$500 per day*

Benefits for the Annual Hospitalization Confinement Benefit are limited to a total benefit payment of five days per calendar year, per policy. Confinements not separated by 30 days or more, or hospitalization that begins prior to the end of one calendar year and continues into the next calendar year, will be considered one confinement.

Daily Hospital Confinement Benefit

Aflac will pay $100 per day for the period of hospital confinement* when a covered person requires hospital confinement for a covered sickness or injury. This benefit is payable in addition to the Annual Hospitalization Confinement Benefit. The maximum benefit period for any one period of hospital confinement is 365 days. No lifetime maximum.

*Hospital confinement does not include emergency rooms. Treatment or confinement in a U.S. government hospital does not require a charge for benefits to be payable.

Rehabilitation Unit Benefit

Aflac will pay $100 per day for each day you are charged when a covered person is confined in a hospital and is transferred to a bed in a rehabilitation unit of a hospital for a covered sickness or injury. This benefit is limited to 15 days for each covered person per period of hospital confinement and is limited to a calendar year maximum of 30 days per covered person. No lifetime maximum.

Invasive Diagnostic Exams Benefit

Aflac will pay $100 when a covered person requires one of the following exams and a charge is incurred: arthroscopy, bronchoscopy, colonoscopy, cystoscopy, gastroscopy, laryngoscopy, sigmoidoscopy, esophagoscopy, or myringoscopy. These exams must be performed in a hospital or an ambulatory surgical center. Only one benefit is payable per 24-hour period, per covered person. When an invasive diagnostic exam and a surgical benefit are performed on the same day, only one benefit is payable per 24-hour period. The highest eligible benefit will be paid. No lifetime maximum.

Surgical Benefit

Aflac will pay $50–$1,000 when a surgical operation is performed, including a vaginal or cesarean delivery, on a covered person for a covered sickness or injury in a hospital or an ambulatory surgical center. If any operation for the treatment of the covered sickness or injury is performed other than those listed, Aflac will pay an amount comparable to the amount shown in the Schedule of Operations for the operation most nearly similar in severity and gravity. Only one benefit is payable per 24-hour period for surgery, even though more than one surgical procedure may be performed. The highest eligible benefit will be paid. Exams covered under the Invasive Diagnostic Exams Benefit are not payable under this benefit. No lifetime maximum.

Surgical Benefits are not payable for surgery performed in a doctor's or dentist's office, clinic, or other such location. Surgical Benefits are not payable for losses caused by or resulting from elective surgery that is not medically necessary within the first 12 months of the effective date of the policy unless the loss begins after 12 months from the effective date of the policy.

Outpatient Surgical Room Charge Benefit

Aflac will pay the amount listed below when a covered person has a surgical operation or an invasive diagnostic exam performed on an outpatient basis in a hospital, including an ambulatory surgical center. This benefit is not payable on the same day as the Hospital Confinement Benefit. No lifetime maximum on the number of operations.

Surgical operation or invasive diagnostic exam with general anesthesia	*$300*
Surgical operation or invasive diagnostic exam without general anesthesia	*$100*

Waiver of Premium Benefit

Aflac will waive from month to month, for the named insured only, any premium(s) falling due during the named insured's continued hospital confinement. This benefit will begin after the named insured has received Daily Hospital Confinement Benefits from the policy for 30 consecutive days. When Daily Hospital Confinement Benefits are no longer being paid, premium payments must be resumed. Once premium payments are resumed, any new confinements must again satisfy the 30-day continued confinement for premiums to be waived. If you die and your spouse becomes the new named insured, premiums will start again at the appropriate rate and will be due on the first premium due date after the change. The new named insured will then be eligible for this benefit if the need arises.

Guaranteed-Renewable
The policy is guaranteed-renewable for your lifetime, subject to Aflac's right to change premiums by class upon any renewal date.

Family Coverage
Family coverage includes the insured; spouse; and dependent, unmarried children to age 19 (or 25 if they are full-time students). Newborn children are automatically insured from the moment of birth. One-parent family coverage includes the insured and dependent, unmarried children to age 19 (or 25 if they are full-time students). A dependent child must be under age 19 at the time of application to be eligible for coverage.

Effective Date
The effective date is the date shown in the Policy Schedule, not the date the application is signed. Payroll rates may be retained after one month's premium payment on payroll deduction.

Pre-Existing Conditions
A pre-existing condition is an illness, disease, or disorder for which, within the 12-month period before the effective date of coverage, medical advice, consultation, or treatment was recommended or received, or for which symptoms existed that would ordinarily cause a prudent person to seek diagnosis, care, or treatment. Care or treatment caused by a pre-existing condition will not be covered unless it begins more than six months after the effective date of coverage. A sickness is an illness, disease, or disorder, independent of injury, diagnosed or treated more than 30 days after the effective date of coverage and while coverage is in force.

Limitations and Exclusions
Any illness, disease, or disorder diagnosed by a physician or medically treated during the 12 months prior to the effective date of the policy will not be covered, unless the loss begins more than six months after the effective date of the policy. Benefits are not payable for any illness, disease, or disorder that is diagnosed by a physician or medically treated before coverage has been in force 30 days from the effective date shown in the Policy Schedule, unless the loss begins more than six months after the effective date of the policy. Benefits for a covered sickness for all persons added to the policy (including newborns) are subject to a 30-day waiting period. Aflac will waive the waiting period for newborns added after the policy has been in force for ten full months.

The policy does not cover losses caused by or resulting from intentionally self-inflicting bodily injury or attempting suicide; participating in or attempting to participate in any illegal activity that is classified as a felony, whether charged or not (the term felony is as defined by the law of the jurisdiction in which the activity takes place); being exposed to war or any act of war, declared or undeclared, or actively serving in any of the armed forces or units auxiliary thereto, including the National Guard or Reserve; having treatment for a mental or nervous disorder or disease; alcoholism or drug dependency; any loss sustained or contracted due to a covered person's being intoxicated or under the influence of alcohol, drugs, or any narcotic unless administered on the advice of a physician and taken according to the physician's instructions (the term intoxicated refers to that condition as defined by the law of the jurisdiction in which the injury or cause of the loss occurred); having cosmetic surgery that is not medically necessary; having elective surgery that is not medically necessary within the first 12 months of the effective date of the policy; pregnancy or childbirth within the first ten months of the effective date of the policy (complications of pregnancy will be covered to the same extent as a sickness); routine nursing or well-baby care for a newborn child; being hospitalized before the effective date of coverage; or donating an organ within the first 12 months of the effective date of the policy.

If the period of hospital confinement follows a previously covered confinement, it will be deemed a continuation of the first confinement unless the later confinement is the result of an entirely unrelated sickness or injury, or the confinements are separated by 30 days or more during which the covered person is not confined in any institution or facility.

A physician does not include a member of your immediate family.

Hospital does not include any institution or part thereof used as an emergency room; a rehabilitation unit; a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a psychiatric unit; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial or educational care, care or treatment for persons suffering from mental disease or disorders, care for the aged, or care for persons addicted to drugs or alcohol. Benefits for confinement in a rehabilitation unit are payable under the Rehabilitation Unit Benefit.

Complications of pregnancy do not include premature delivery without incidence, false labor, occasional spotting, prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy not constituting a classifiably distinct complication of pregnancy. Cesarean deliveries are not considered complications of pregnancy.

Aflac is ...

- A Fortune 500 company with nearly $60 billion in assets, insuring more than 40 million people worldwide.
- Rated AA in insurer financial strength by Standard & Poor's (June 2006), Aa2 (Excellent) in insurer financial strength by Moody's Investors Service (January 2006), A+ (Superior) by A.M. Best (June 2006), and AA in insurer financial strength by Fitch, Inc. (June 2006).*
- Named by Fortune magazine to its list of America's Most Admired Companies for the seventh consecutive year in March 2007.
- A premier provider of insurance policies with premiums payroll deducted for more than 370,000 payroll accounts nationally.
- Outstanding in claims service, with most claims processed within four days.
- Included by Forbes magazine in its annual list of America's 400 Best Big Companies for the seventh year in January 2007.
- Named by Fortune magazine to its list of the 100 Best Companies to Work For in America for the ninth consecutive year in January 2007.

**Ratings refer only to the overall financial status of Aflac and are not recommendations of specific policy provisions, rates, or practices.*

1.800.99.AFLAC (1.800.992.3522)

En español:
1.800.SI.AFLAC (1.800.742.3522)

Visit our Web site at aflac.com.

Your local Aflac insurance agent/producer

Investment Summary

City of Jonesboro
124 North Ave
Jonesboro, GA 30236
United States

Today's Date: **8/30/2016**
Quote Number: **02-2016-1751137.2**

Executive Contact
Joy Day
City Mayor
jday@jonesboroga.com
(770) 478-3800

ADP Sales Associate
Jason Kane
jason.kane@adp.com
(770) 905-4427

Control # 1 : Quote based on an estimated 59 pays,paid Bi-Weekly

HCM: **$6.50 per employee per month**
TIME: **$5.00 per employee per month; $100.00 Minimum Monthly Fee applies**

Annual Investment:	**$8,142.00**
Implementation Cost:	**$5,000.00**
Expiration Date:	**9/19/2016**

SALES ORDER

City of Jonesboro
124 North Ave
Jonesboro, GA 30236
United States

Today's Date: **8/30/2016**
Quote Number: **02-2016-1751137.2**

Control Start Date:

Executive Contact
Joy Day
City Mayor
jday@jonesboroga.com
(770) 478-3800

ADP Sales Associate
Jason Kane
jason.kane@adp.com
(770) 905-4427

Number of Employees for Payroll processing : 59 on control: City of Jonesboro

Monthly Fees	Count	Min	Base	Rate	Monthly Fee	Annual Tot
Workforce Now HR Solutions	59			$6.50	$383.50	$4,602
Workforce Now HR & Benefits						
ADP Portal with Customized Content		Employee and Manager Self Service				
Policy Acknowledgement		Paid Time Off (PTO) Accruals Engine				
Organization Charting		Multiple Benefit Plan Types				
Employee Development Tracking		Flexible Rate Structures				
Compliance Reporting		Notifications & Approvals				
Custom Fields		Dependent & Beneficiary Tracking				
Global HR System of Record:		Employee Open Enrollment				
- Multiple Language & Currencies		ACA Measurement Dashboard				
- Country Specific Workflows & Processes		Invoice Auditing				
- Country Specific Custom Fields & Formatting		Cobra Event Triggers				
Essential ACA						
Annual 1094c/1095c Filing		Evidence of Benefit Offering Screens & Reporting				
Workforce Now Essential Time and Attendance	59	$100.00		$5.00	$295.00	$3,540.
Essential Time						
Time Collection		Rule Based Calculations				
PTO Management & Reporting		Scheduling				
Request & Approval Workflows		Mobile Access				
ADP Portal with Customized Content		Paid Time Off Accruals				

Billing for Essential Time will begin on the earlier of (i) the date the ADP Product or Service is available for use by the client in a production environment OR (II) ninety (90) days from the date of this sales order. The billing counts for Essential Time are based on all non-terminated employees in the Time Module.

Sub Total					$678.50	$8,142.(

Invoice Details	Unit Fees	
Implementation Fees	**Count**	**One Time F**
Implementation for Workforce Now HR Solutions	1	$3,300.(
Implementation WFN Essential Time & Attendance	1	$1,700.(
ACA Historical Hours Import: Client will upload hours history themselves	N/A	N
Sub Total		$5,000.(

Summary

Annual Total of Monthly Fees	$8,142.00
Total One-Time Fees (Total of all one-time fees)	$5,000.00

Start Date Type	Start Date
HR	1/4/2017
Time	1/4/2017

Contact Type	Contact	Phone
HR	Ricky Clark	(770) 478-3800
Payroll	Ricky Clark	(770) 478-3800
Time	Ricky Clark	(770) 478-3800
Executive	Joy Day	(770) 478-3800
Client Security Master	Ricky Clark	(770) 478-3800
Primary	Ricky Clark	(770) 478-3800

Control Summary

	Control Name	Company Code	Pays
Control 1	City of Jonesboro	A9P	59

Client agrees to direct debit of fees for service: Yes

Expiration Date: **9/19/2016**

THE ADP SERVICES LISTED ON THIS SALES ORDER ARE PROVIDED AT THE PRICES SET FORTH ON THE ABOVE PAGES AND IN ACCORDANCE WITH AL STANDARD TERMS AND CONDITIONS OF SERVICE ATTACHED TO THIS SALES ORDER. BY SIGNING BELOW YOU ARE ACKNOWLEDGING RECEIPT OF AND AGREEMENT TO SUCH TERMS AND CONDITIONS AND TO THE LISTED PRICES.

ADP, LLC

By: _____

Name: _____

Title: _____

Date: _____

Client:

By: _____

Name: _____

Title: _____

Date: _____

ADP WorkforceNow

ADP Major Accounts Services
AMENDMENT TO MASTER SERVICES AGREEMENT

8/30/2016
(Effective Date)

ADP, LLC: One ADP Boulevard
Roseland, New Jersey 07068
(referred to herein as "ADP")

CLIENT: City of Jonesboro
124 North Ave Jonesboro, GA 30236, United States
(referred to herein as "Client")

Attention: Joy Day

This Amendment modifies, amends, and supplements the terms and conditions of the ADP Major Accounts Services - Master Services Agreement (or Major Accounts Agreement or such equivalent terms and conditions or agreement governing the provision and receipt of ADP's Major Account's services including but not limited to any product specific terms set forth in such prior agreement) between ADP and Client (the "Agreement") and each Annex listed below is added and incorporated into the Agreement in full by this reference as if set forth in the Agreement in full.

ANNEX C:	TIME AND ATTENDANCE SERVICES
ANNEX D:	HR, BENEFITS AND TALENT MANAGEMENT SERVICES
ANNEX E:	ESSENTIAL ACA

BY SIGNING BELOW, CLIENT ACKNOWLEDGES THAT THEY HAVE REVIEWED THE ENTIRE AMENDMENT INCLUDING THE TERMS AND CONDITIONS IN EACH ANNEX CORRESPONDING TO SERVICES PURCHASED PURSUANT TO THE SALES ORDER.

If there is a conflict between this Amendment and the Agreement (including any prior addendum or amendment to Agreement) between Client and ADP (or if such Agreement contained terms for services that were not purchased at the time it was executed), this Amendment shall govern with respect to the services listed above. The terms set forth herein replace in their entirety any duplicative terms set forth in Client's prior agreement for services.

ADP, LLC	**CLIENT**
(Signature of Authorized Representative)	(Signature of Authorized Representative)
(Name - Please Print)	(Name - Please Print)
(Title) (Date)	(Title) (Date)

ADP WorkforceNow

ANNEX C
TIME AND ATTENDANCE SERVICES

1. **Time and Attendance Products**. ADP agrees to provide Client with the data collection devices (e.g. Timeclock, HandPunch, etc.) (the "**Timeclock Equipment**"), time and attendance module or application, and related services (collectively, the "**Time Products**") described in the Sales Order. For the hosted Enhanced Time (also known as Enterprise eTIME) product only, additional license terms are available at www.adp.com/tlmlicenseterms. ADP Enhanced and Essential Time products are available for use in a limited number of countries outside the United States, although certain restrictions and requirements may apply.
2. **Billing for Services**. If Client is purchasing Essential Time Services and the pricing for such ADP Products and Services is not bundled with Client's pricing for Payroll Processing services, if any, billing for such ADP Products and Services will begin on the earlier of (i) the date that ADP Products and Services are available for use by Client in a production environment OR (ii) ninety (90) days from the Effective Date. If Client is purchasing Enhanced Time (also known as Enterprise eTIME) services billing will begin on the earlier of (i) the date that ADP Products and Services are available for use by Client in a production environment OR (ii) one hundred forty (140) days from the Effective Date. If the Services Client is purchasing pursuant to this Annex C is bundled with payroll processing services, then billing for such services shall commence in accordance with the terms of Section 2 of Annex B.
3. **Installation**. Client shall provide and install all power, wiring and cabling required for the installation of any Timeclock Equipment. Client shall also pay an installation and setup fee for each unit of Timeclock Equipment if such equipment is installed on Client's premises by ADP.
4. **Use of Timeclock Equipment and Right to Inspect**. Regarding Timeclock Equipment provided on a subscription basis only, Client shall not make any alterations or attach any device not provided by ADP to the Timeclock Equipment, nor shall Client remove the Timeclock Equipment from the place of original installation without ADP's prior consent. Upon reasonable written notice to Client, ADP shall have the right to enter Client's premises to inspect the Timeclock Equipment during normal business hours. Title to the Timeclock Equipment shall at all times remain in ADP unless Client has chosen the purchase option and has paid ADP in full the purchase price. Except if so purchased and paid for by Client, the Timeclock Equipment is and at all times shall remain, a separate item of personal property notwithstanding its attachment to other Timeclock Equipment or real property.
5. **Return of Timeclock Equipment**. Upon termination or cancellation of this Agreement, Client shall, at its expense, return the Timeclock Equipment to ADP in accordance with ADP's instructions. The Timeclock Equipment shall be returned in as good condition as received by Client, normal wear and tear excepted. In the event the Timeclock Equipment is not returned within ninety (90) days, Client agrees to purchase it at the prevailing manufacturer's suggested retail price. If timely payment for the Timeclock Equipment is not made by Client, ADP shall have the right to take immediate possession of such equipment. The terms of this Section 5 shall not apply if prior to the time of such termination or cancellation Client already purchased and paid for the Timeclock Equipment in full.
6. **Warranty**. ADP warrants to Client that the Timeclock Equipment shall be free from defects in material and workmanship at the date such Timeclock Equipment is shipped and for ninety (90) days thereafter. ADP's sole obligation in case of any breach of any warranty contained herein shall be to repair or replace, at ADP's option, any defective items. The foregoing is the extent of ADP's liability with respect to all claims related to Timeclock Equipment, including without limitation, contract and negligence claims and shall constitute Client's sole remedy.
7. **Maintenance Fees**. Maintenance services for the Timeclock Equipment (set forth below in Section 8) apply automatically to Timeclock Equipment obtained under the subscription option (and any charges therefore are already included in the monthly time and attendance subscription fees). The costs for maintenance services for Timeclock Equipment under the purchase option are not included in the purchase price for such equipment; a separate annual maintenance fee applies. Client, under the purchase option, may terminate its receipt of maintenance services by providing written notice to ADP no less than thirty (30) days prior to the end of the then current annual coverage period. ADP is not required to rebate to Client any maintenance fees relating to a current or prior coverage period. (NOTE: If Client selects the purchase option but opts not to receive (or terminates) maintenance services hereunder by executing a waiver of maintenance services, any such services provided by ADP at Client's request will be subject to ADP's then current charges for such services.) No Timeclock Equipment maintenance is done at the Client site. Client shall bear all delivery/shipping costs and all risk of loss during shipment/delivery of Timeclock Equipment relating to maintenance services.
8. **Maintenance Services**. ADP will maintain the Timeclock Equipment to be free from defects in material and workmanship as follows: Any parts found to be defective (except as specifically excluded below) shall be replaced or repaired, at ADP's or its designee's option, without charge for parts or labor, provided that the Timeclock Equipment has been properly installed and maintained by Client and provided that such equipment has been used in accordance with this Agreement and any online or shrink-wrap terms or license, or other accompanying documentation including, but not limited to, Client's Sales Order provided by ADP or its designee and has not been subject to abuse or tampering. The foregoing repairs and replacements may be made only by ADP or its designee, and will be made only after ADP or its designee is notified of a problem, receives delivery from Client of the Timeclock Equipment at issue and determines that it results from defective materials or workmanship. Notwithstanding the foregoing, ADP may deliver a temporary replacement item for Client's use while such determination is being made with respect to the Timeclock Equipment in question. Repairs and replacements required as a result of any of the following shall not be included in the foregoing maintenance services and shall be charged at ADP's then current rates: (i) damage, defects, or malfunctions resulting from misuse, accident, neglect, tampering, unusual physical, or electrical stress, or causes other than normal or intended use; (ii) failure of Client to provide and maintain a suitable installation environment; (iii) any alterations made to or any devices not provided by ADP attached to the Timeclock Equipment; and (iv) malfunctions resulting from use of badges or supplies not approved by ADP.
9. **Upgrades**. In order to keep the Time Products current, ADP may from time to time perform maintenance fixes and other upgrades to the Time Products Client is then receiving. ADP will perform these upgrades on Client's behalf for all hosted products. For non-hosted products, Client will be required to install the upgrade provided by ADP in accordance with the written notice provided to Client.

ADP WorkforceNow

ANNEX D
HR, BENEFITS AND TALENT MANAGEMENT SERVICES

1. **Billing for Services**. If Client is purchasing HR, Benefits or Talent Management Services and the pricing for such Services is not bundled with Client's pricing for payroll processing services, billing for such Services will begin on the earlier of (i) the date that the services are available for use by Client in a production environment OR (ii) ninety (90) days after the Effective Date. The billing count for HR, Benefits or Talent Management Services and the pricing for such Services is not bundled with Client's pricing for payroll processing services is based on all unique lives in the database paid in the previous calendar month. If the Services Client is purchasing pursuant to this Annex D are bundled with payroll processing services, then billing for such Services shall commence in accordance with the terms of Section 2 of Annex B.
2. **Initial Setup Services**. Client shall promptly deliver to ADP the Client Content required by ADP to perform initial setup services. Such information and materials shall be in an electronic file format acceptable to ADP.
3. **Additional Configuration**. After completion of initial setup services, any subsequent changes Client requests to the configuration of the Client Content in the HR and/or Benefits module will be charged at ADP's then current benefits maintenance fees.
4. **ADP Carrier Connection®**. If Client is receiving the Benefits products and services and elects the ADP Carrier Connection service, ADP, or its authorized agent(s), will electronically transmit employee data, including employee benefits enrollment data, to Client's carriers or other third parties authorized by Client, and Client authorizes ADP and its authorized agent(s), to provide such transmission on Client's behalf. Additionally, commencement of the Carrier Connection service is subject to Client completing the configuration setup of Client Content and the format of such transmission to the designated carriers. ADP's ability to transmit Client's employee benefits enrollment data is subject to the provision by the designated carriers of a current functional interface between the benefits module and the designated carriers' systems. ADP will not be obligated to transmit Client's data to the designated carriers if at any time Client's designated carriers fail to provide the proper interface as described above. If Client requires the development of any special interfaces in order to transmit such data to the designated carriers, all work performed by ADP to create such interfaces will be at ADP's then current fees for such services. Client is responsible for promptly reviewing all records of carrier transmissions and other reports prepared by ADP for validity and accuracy according to Client's records, and Client will notify ADP of any discrepancies promptly after receipt thereof. In the event of an error or omission in the Carrier Connection services caused by ADP, ADP will correct such error or omission, provided that Client promptly advises ADP of such error or omission. Client shall remain responsible for transmission of all enrollment/disenrollment data to Client's carriers other third parties authorized by Client until ADP confirms that carrier connection implementation is complete. Additional setup fees will apply when Client elects to add new carrier connections. This includes reconfiguration of existing carrier connections and additional elections requested after connection set up (initial implementation) of the Services. Any changes in Client's benefit providers that require the establishment of a new carrier connection or the modification of an existing carrier connection shall be considered a new carrier connection.
5. **Talent Management Services.** Talent Management Services includes Performance, Recruitment and Compensation Management products and services. If Talent Management Services are purchased, the following additional provisions will apply.
   - **A. Hiring Practices**. Client represents and warrants that it will use Talent Management Services for its own hiring and/or HR management purposes only. Client acknowledges and agrees that ADP will not be deemed to be involved in any hiring decisions or evaluation of candidates in connection with the recruitment services, or with any compensation decisions in connection with the compensation management services.
   - **B. Customized Content**. Client understands and agrees that to the extent it chooses to customize any content or documents made available to job candidates through Talent Management Services, including but not limited to job descriptions, online application instructions and questions, Client is responsible for the content of any such customization. Client acknowledges that any content provided by the Talent Management Services may not be suitable for all situations or in all locations. Client should review applicable laws in the jurisdictions in which Client operates and should consult with its own legal counsel prior to utilizing the services.
   - **C. Sensitive Data**. If Client implements the Talent Management Services to collect any sensitive data elements (or special categories of data), Client shall comply with any additional requirements for the processing of these data elements, and it shall be responsible for respecting all individual rights of access, correction or deletion and for responding to any individual or regulatory inquiries.

ADP WorkforceNow

ANNEX E
Essential ACA

1. **Description.** ADP will provide the Essential ACA solution specified in the Sales Order (and any applicable service specification) (collectively, the "**Essential ACA**") to Client in accordance with the terms of this Agreement. Essential ACA is a technology and software solution to assist Client in managing compliance needs related to the Affordable Care Act (ACA), including eligibility calculations and affordability determinations, preparation and electronic filing of Forms 1094-C and 1095-C forms, access to evidence of benefit offering information and benefit offering audit reports. Client must use ADP Workforce Now payroll, HR and benefits services in order to purchase and implement Essential ACA. For those clients that purchase Essential ACA within the 2016 order window (as communicated by ADP to Client based on client status, Workforce Now version and benefits module status as of Effective Date), Essential ACA will commence for the 2016 filing period. If Client purchases Essential ACA after the close of the 2016 order window, Essential ACA will commence in calendar year 2017 (and will not include any filings for the 2016 filing period). For the avoidance of doubt, all Forms filed by ADP with the IRS on behalf of Client will be filed electronically; any Forms sent to Client for its employees by ADP shall be sent in paper form, and, if Client has ADP's iPay functionality, ADP will also make Forms accessible to Client employees electronically. It will then be Client's responsibility to distribute the Forms directly to its employees.
2. **Billing for Services**. If Client is purchasing Essential ACA Services and the pricing for such Services is not bundled with Client's pricing for payroll processing services, billing for such Services will begin on the earlier of (i) the date that the services are available for use by Client in a production environment OR (ii) ninety (90) days from the Effective Date. If the Services Client is purchasing pursuant to this Annex E are bundled with payroll processing services, then billing for such Services shall commence in accordance with the terms of Section 2 of Annex B.
3. **Delivery of Client Content.** Client shall promptly deliver to ADP the Client Content as required by ADP in an electronic file format specified by and accessible to ADP and will include any materials relating to Client and necessary for incorporation in the Essential ACA solution, including, but not limited to, any Human Resources, Payroll, Time and Labor, Benefits, Form I-9, and/or financial data.
4. **Client ACA Liaison.** Prior to the commencement of ADP's provision of the Essential ACA solution, Client shall designate in writing to ADP the name of one person who shall serve as ADP's principal designated contact for the Essential ACA solution (the "Client ACA Liaison"). Client hereby represents and warrants to ADP that the Client ACA Liaison has, and shall at all times have, the requisite authority to transmit information, directions and instructions on behalf of Client. The Client ACA Liaison also shall be deemed to have authority to issue, execute, grant, or provide any approvals (other than amendments to this Agreement), requests, notices, or other communications required or permitted under this Agreement or requested by ADP in connection with the Essential ACA solution. Client shall designate an alternate Client ACA Liaison in the event the principal Client ACA Liaison is not available.
5. **Client Instructions.** In the event ADP shall have any questions relating to a particular set of facts or Client directions, then ADP shall request clarification from the Client ACA Liaison. The Client ACA Liaison shall have the responsibility to obtain answers to any such questions or objections and ADP shall be entitled to rely upon such answers and to follow any directions communicated by the Client ACA Liaison. Client authorizes ADP to release employee-related data to third party vendors of Client as are designated by Client from time to time. ADP shall be under no duty to question the measures taken or directions provided by Client pursuant to any section of this Annex E.
6. **Disclaimer. NOTWITHSTANDING ANYTHING TO THE CONTRARY CONTAINED HEREIN OR IN THE SCOPE OF SERVICES, CLIENT EXPRESSLY ACKNOWLEDGES THAT ADP IS NOT THE "ADMINISTRATOR" OR "PLAN ADMINISTRATOR" AS DEFINED IN SECTION 3(16)(A) OF ERISA AND SECTION 414(g) OF THE INTERNAL REVENUE CODE, RESPECTIVELY, NOR IS ADP A "FIDUCIARY" WITHIN THE MEANING OF ERISA SECTION 3(21). ADP SHALL NOT EXERCISE ANY DISCRETIONARY AUTHORITY OR DISCRETIONARY CONTROL RESPECTING MANAGEMENT OF ANY BENEFIT PLANS SPONSORED OR OFFERED BY CLIENT. ADP HAS NO DISCRETIONARY AUTHORITY OR DISCRETIONARY RESPONSIBILITY IN THE ADMINISTRATION OF THE CLIENT'S BENEFIT PLAN(S).**
7. **Implementation Services.** ADP will assist Client in implementing the Essential ACA solution for the benefit of and in conjunction with Client in accordance with the provisions of Sections 7 and 8 below. ADP will use commercially reasonable efforts to complete the implementation services in a timely manner.
8. **Conversion of Data; Required Timeline.** Client shall provide to ADP, such applicable Client files, databases and other information (the "Client Files") as is necessary to permit the Essential ACA solution to be performed. Client must provide the Client Files to ADP by November 1st of the year preceding the year in which the preparation and electronic filing of the Forms will be provided. For purposes of clarification and example, in order for ADP to perform the preparation and electronic filing of the Forms in January of the current filing year, Client must provide the Client Files in accordance with the terms and conditions of this Annex, and such Client Files must be accepted and converted by ADP by December 9 of the previous year. Client assumes the responsibility for the Client Files to be transmitted to ADP, including, but not limited to, their condition, content, format, usability or correctness. Client shall perform all Client Files refinement, purification and reformatting in order for the Essential ACA solution to be performed by ADP. With Client's pre-approval, ADP shall be compensated on a time and expense basis at ADP's standard rates in effect at such time in the event ADP is required to perform any such refinement, purification or reformatting. Client will cooperate with ADP and provide ADP with all necessary information and assistance required in order for ADP to successfully convert the Client Files. Client understands and agrees that if Client fails to provide the Client Files in order for such Client Files to be accepted and successfully converted by November 1st, in any given year, ADP will not provide the preparation and electronic filing of the Forms for that year and Client will not be eligible for credit of any fees paid for the Essential ACA solution for that year. Client is responsible for the accuracy of all Client Files and will review for accuracy the preview of the Forms prior to filing. In the event that a Form 1094-C or 1095-C needs to be refiled due to an inaccuracy in the Client Files, Client will be billed for such refiling. The obligations described in this Section 7 shall apply to ongoing provision of Client Files to ADP by Client.

9. **Project Lead.** Client will designate a project lead for the implementation of the Essential ACA solution and will promptly notify ADP of the name, telephone number and email address of such person. The Client project lead will be deemed to have authority to issue, execute, grant, or provide any approvals, requests, notices, or other communications required under this Annex E or requested by the other party in connection with the implementation of the Essential ACA solution. The project lead will bring appropriate personnel/skillsets to the project as needed.
10. **Licensed Entity.** Notwithstanding the use in this Annex E of the word "ADP", in the event that ADP determines that all or a portion of the Essential ACA solution may be subject to licensing or other regulatory requirements, such services shall be performed solely by such wholly owned subsidiary of Automatic Data Processing, Inc. as shall be designated by ADP or such licensed third party as determined by ADP.

ADP Workforce Now® HR Management

A more human resour

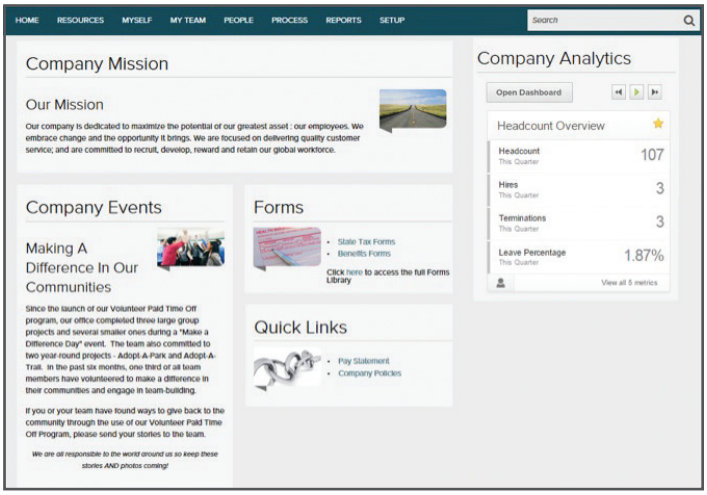
ADP has the people, processes and technology you need to help transform Human Resources management from an administrative function to a powerful, vital and strategic part of your business.

And it starts with simplicity. By automating HR management, you can streamline activity and free up resources to focus on the more strategic opportunities and core activities that help your business grow and compete.

How can ADP's Workforce Now® solution help you streamline and simplify HR management?

Through our suite of leading edge HR tools, we help you by delivering:

- Tools to help you stay compliant with Health Care Reform changes.
- Reports that help make smarter hiring decisions.
- Customizable tools to fit the way you work and your existing hiring process.



ADP Workforce Now Portal

*HR Management Features**	*Essential*	*Enhanced*
Basic HR Recordkeeping	YES	YES
Standard Compliance Reports	YES	YES
Custom Fields	YES	YES
Portal Content Management	YES	YES
Global HR System of Record	NO	YES
Multi-Currency Tracking	NO	YES
Country-Specific Custom Fields	NO	YES
Manage Paid Time Off Accruals	YES	YES
Customized Content within Portal	NO	YES

* NOTE: This list is not inclusive of all features. For the full feature set, contact your Sales Representative or call 800.CALL.ADP (800-225-5237)

Managing Globally

The challenges of managing a global workforce are formidable. Doing business in multiple countries can reduce visibility into your personnel and increase your organization's complexity, while also introducing new risks.

Here are some of the ways in which ADP's Workforce Now Global HR System of Records** can help you:

- Customize onboarding in certain countries to build business processes that are specific to the country of employment to help ensure only relevant information is collected and maintained in ADP Workforce Now.
- Supports your growth through dynamic scaling.
- Features easy installation as well as data availability – ADP Workforce Now functionality is always there – accessible via any PC or mobile device.
- Verify entries at a glance before calculating the payroll.
- Easy new hire templates make sure you quickly get new hires paid.

** Not available in every country

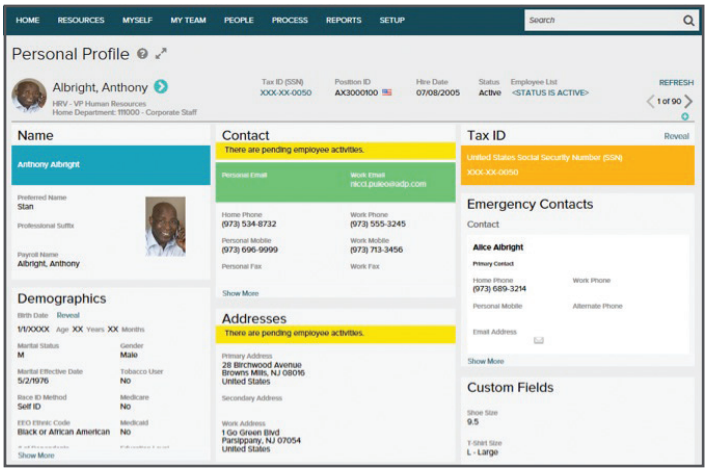
Effectively Manage the Employee Life Cycle

New laws, changing regulations, and the need to provide timely information to your employees — and to the government — can place tremendous demands on your staff time and resources.

ADP Workforce Now helps you stay compliant across the employee life cycle, putting you in control from HR to payroll to employer-related compliance administration in the United States and Canada.

With full integration with payroll, benefits, and time and attendance, you can in the United States and Canada:

- Access, manage, and analyze sensitive or complex HR information, like salaries and pay grades for performance reviews.
- Improve employee recordkeeping.
- Gain convenient access to standard reports that help you maintain compliance with government regulations concerning COBRA and EEO administration as well as OSHA events.



Employee Recordkeeping

ADP Workforce Now — All-In-One HCM. Your single provider for payroll, talent management, human resource management, benefits administration, and time and attendance.

For more information, contact your Sales Representative or call 800.CALL.ADP (800-225-5237)

CITY OF JONESBORO, GEORGIA COUNCIL
Agenda Item Summary

Agenda Item # 9.C
– C

COUNCIL MEETING DATE
September 12, 2016

Requesting Agency (Initiator)	**Sponsor(s)**
City Council	Mayor Day

Requested Action *(Identify appropriate Action or Motion, purpose, cost, timeframe, etc.)*
Council to consider the appointment of Allen Roark to the Jonesboro Housing Authority to complete the unexpired term of James Henry to expire June 9, 2017.

Requirement for Board Action *(Cite specific Council policy, statute or code requirement)*
Bylaws of Housing Authority

Is this Item Goal Related? *(If yes, describe how this action meets the specific Board Focus Area or Goal)*

Summary & Background *(First sentence includes Agency recommendation. Provide an executive summary of the action that gives an overview of the relevant details for the item.)*

The Bylaws of the Authority, provides for five (5) members on the Board of Commissioners for the Authority, four (4) of whom shall be persons who have resided in Clayton County for a period of at least six (6) months, and one (1) person who is currently residing in housing provided by the Authority.

City resident, Allen Roark is agreeing to serve to complete the unexpired term of James Henry.

Fiscal Impact *(Include projected cost, approved budget amount and account number, source of funds, and any future funding requirements.)*

N/A

Exhibits Attached (Provide copies of originals, number exhibits consecutively, and label all exhibits in the upper right corner.)

- RES 2016-13- Jonesboro Housing Authority Appointments

Staff Recommendation *(Type Name, Title, Agency and Phone)*

Confirmation

FOLLOW-UP APPROVAL ACTION (City Clerk)

Typed Name and Title	**Date**	
Ricky Clark, City Administrator	September, 12, 2016	09/06/16 City Council CONSENT AGENDA ITEM Next: 09/12/16
Signature	**City Clerk's Office**	

STATE OF GEORGIA
COUNTY OF CLAYTON

RESOLUTION NO. 2016- 13

A RESOLUTION BY THE CITY COUNCIL FOR THE CITY OF JONESBORO, GEORGIA, TO APPOINT & REAPPOINT MEMBERS TO THE BOARD OF COMMISSIONERS FOR THE HOUSING AUTHORITY OF THE CITY OF JONESBORO, GEORGIA; TO PROVIDE FOR SEVERABILITY; TO REPEAL ALL RESOLUTIONS AND PARTS OF RESOLUTIONS IN CONFLICT HEREWITH; TO PROVIDE AN EFFECTIVE DATE; AND FOR OTHER PURPOSES.

WHEREAS, on or about January 18, 1959, the City Council for the City of Jonesboro, Georgia ("the City") adopted a Resolution entitled "Resolution Declaring the Need for Housing Authority in the City of Jonesboro, Georgia," which created and established the Housing Authority of the City of Jonesboro, Georgia ("the Authority") to meet certain housing needs in the City; and

WHEREAS, the Bylaws of the Authority, provides for five (5) members on the Board of Commissioners for the Authority, four (4) of whom shall be persons who have resided in Clayton County for a period of at least six (6) months, and one (1) person who is currently residing in housing provided by the Authority.

WHEREAS, the respective terms of certain members on the Commission is approaching expiration and the Mayor & City Council of the City of Jonesboro wishes to ratify action to keep members terms current.

NOW THEREFORE BE IT RESOLVED BY THE CITY COUNCIL FOR THE CITY OF JONESBORO, GEORGIA, as follows.

Section 1. The following persons are hereby reappointment to serve as members of the Board of Commissioners for the Housing Authority of the City of Jonesboro, Georgia, and are appointed to serve the following terms or until their successors are duly appointed, at the pleasure of the Mayor and City Council:

Allen Roark- [unexpired term of James Henry] to expire- June 9, 2017_

Section 2. Severability. If any section, paragraph, sentence, clause or phrase of this Resolution is held to be invalid or unconstitutional for any reason by a decision of any court of competent jurisdiction, such decision shall not affect the validity of the remaining portions of this Resolution, which such portions shall remain in full force and effect.

Section 3. Repealer. All Resolutions and parts of Resolutions in conflict with this Resolution are hereby repealed to the extent of such conflict.

Section 4. Effective Date. This Resolution shall be in full force and effect immediately upon and after its final passage.

SO RESOLVED this _____ day of _____, 2016.

CITY OF JONESBORO, GEORGIA

_____
Joy Day, MAYOR

ATTEST:

(THE SEAL OF THE CITY OF JONESBORO, GEORGIA)

_____
Ricky L. Clark, Jr., City Administrator

CERTIFICATION OF APPOINTMENT OF COMMISSIONER OF THE HOUSING AUTHORITY OF THE CITY OF JONESBORO

WHEREAS, The Housing Authority of the City of Jonesboro, Georgia has heretofore been duly organized pursuant to the Georgia Housing Authorities Law, as amended

NOW THEREFORE, pursuant to the Georgia Housing Authorities Law, as amended by virtue of my office as Mayor, I hereby reappoint Mr. Allen Roark to serve as Commissioner to complete the unexpired term of James Henry ending on June 9, 2017.

IN WITNESS WHEREOF, I have hereunto signed by name as Mayor of the City of Jonesboro, Georgia and caused the official seal of the City of Jonesboro, affixed hereto
This 12th day of September, 2016

_____
Joy B. Day, MAYOR
City of Jonesboro, Georgia

ATTEST:

_____
Ricky L. Clark, Jr., City Clerk
City of Jonesboro

CERTIFICATE OF CITY CLERK

I hereby certify that the above and foregoing act is a true and correct copy of the Certificate of Appointment of Commissioner of the Housing Authority of the City of Jonesboro, Georgia, filed in the office of the City Clerk on the _____ day of _____, 2016.

Witness my hand and the official seal of the City of Jonesboro, Georgia this _____ day of _____, 2016.

_____
Ricky L. Clark, Jr., City Clerk

(THE SEAL OF THE CITY OF
JONESBORO, GEORGIA)

CITY OF JONESBORO, GEORGIA COUNCIL

Agenda Item Summary

Agenda Item # 10.A

PUBLIC HEARING – A

COUNCIL MEETING DATE
September 12, 2016

Requesting Agency (Initiator)	**Sponsor(s)**
Office of the City Administrator	

Requested Action *(Identify appropriate Action or Motion, purpose, cost, timeframe, etc.)*
Council to consider Conditional Use Permit Application #16CU-007 to allow a Professional & Technical Services Training Facility at property located at 184 North Avenue, Suite 105. (YCDI Institute)

Requirement for Board Action *(Cite specific Council policy, statute or code requirement)*

Is this Item Goal Related? *(If yes, describe how this action meets the specific Board Focus Area or Goal)*
Yes — Community Planning, Neighborhood and Business Revitalization

Summary & Background *(First sentence includes Agency recommendation. Provide an executive summary of the action that gives an overview of the relevant details for the item.)*

The applicant, John Mitchell, is requesting a Conditional Use Permit to allow his tenant, Nathanial Jordan to house a professional & technical services training facility at 184 North Avenue, Suite 105 called YCDI Institute. YCDI has three phases. Phase one is addressing the digital divide which gives youth the opportunity to come in and experience technology that they ordinarily wouldn't have the opportunity to experience. Clients will come in and use computers, and other technology. In addition, they do school homework, projects, experience internet safety first hand, and more. YCDI is also a technology hub that will allow individuals to come in and see the latest educational technology that they can demo before purchasing for their learning environment. YCDI is a non-profit organization with 501c3 status

HISTORY:

1. According to our business license records, this location has served as an office for the following: Adams, Mitchell Realty & ATS Staffing, previously.
2. According to the City's 2025 Future Land Use Map identifies the property as "Office/Business". "Office/Business" includes more intensive office-oriented developments such as "office parks" and "business parks" that are directly accessible to the interstate highway system.
3. This particular office suite/complex houses several different offices around the subject site.

FACTS & ISSUES:

1. Article VI of the Zoning Ordinance outlines the procedure for bringing a Conditional Use Permit application to the Mayor and Council.
2. The Conditional Use requires one acre with 150 feet of road frontage.
3. The Conditional Use also requires that site be located along a collector road or greater.

Fiscal Impact *(Include projected cost, approved budget amount and account number, source of funds, and any future funding requirements.)*

$700 Conditional Use Permit Application Fee

FOLLOW-UP APPROVAL ACTION (City Clerk)

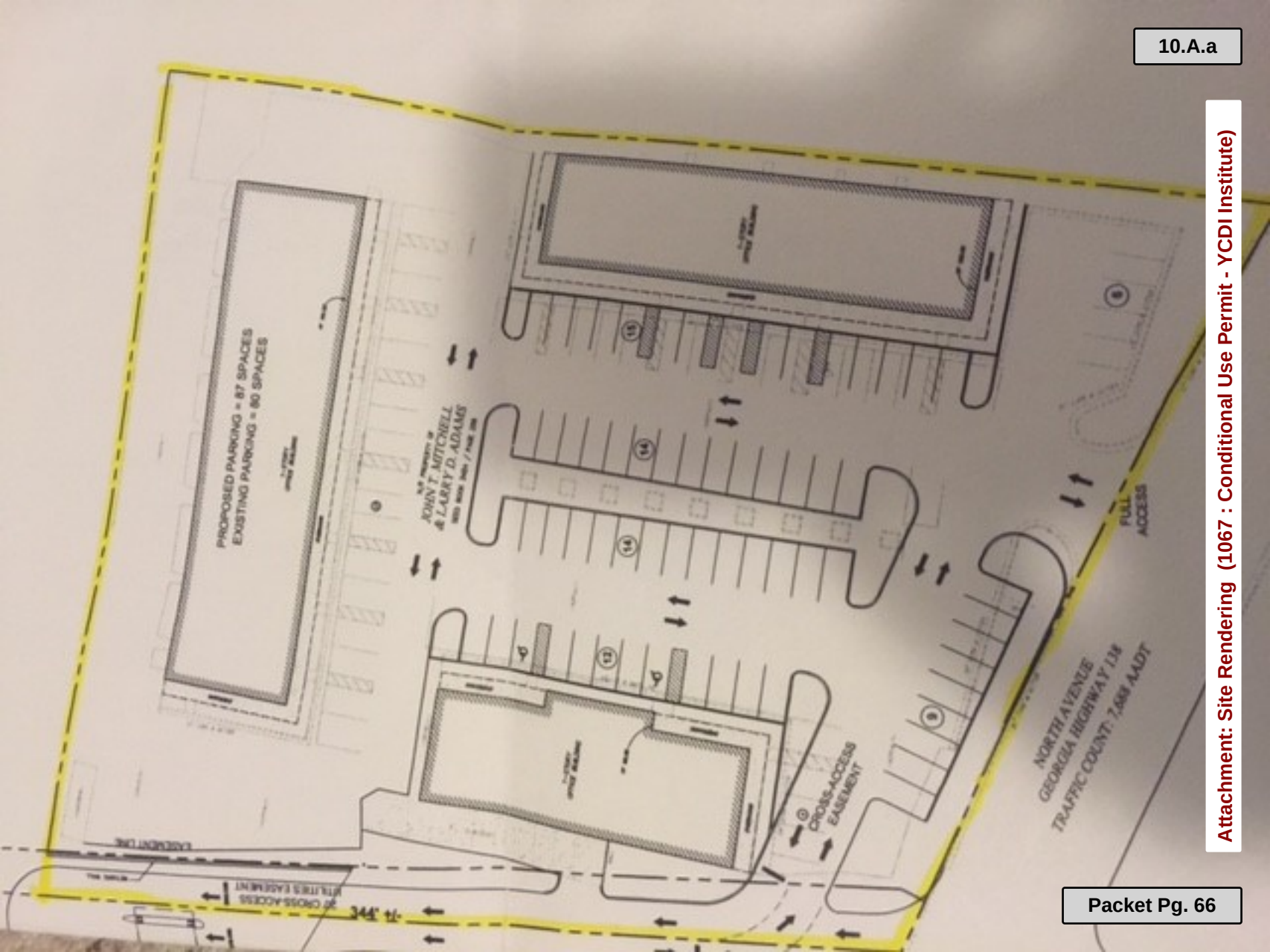
Typed Name and Title	**Date**		
Ricky Clark, City Administrator	September, 12, 2016	**09/06/16**	**City Council OLD BUSINESS** **Next: 09/12/16**
Signature	**City Clerk's Office**		

Exhibits Attached (Provide copies of originals, number exhibits consecutively, and label all exhibits in the upper right corner.)

- Site Rendering
- Condition Use Application - 184 North Avenue

Staff Recommendation *(Type Name, Title, Agency and Phone)*

Approval



Attachment: Site Rendering (1067 : Conditional Use Permit - YCDI Institute)

CITY OF JONESBORO
124 North Avenue
Jonesboro, Georgia 30236
City Hall: (770) 478-3800
Fax: (770) 478-3775
www.jonesboroga.com

CONDITIONAL USE PERMIT
APPLICATION

ATTACH ADDITIONAL PAGES IF NECESSARY. ALL ATTACHMENTS MUST BE NUMBERED. INDICATE THE PAGE NUMBER OF ATTACHMENT IN THE SPACES PROVIDED FOR EACH RELEVANT ANSWER.

ANY MISSTATEMENT OR CONCEALMENT OF FACT IN THIS APPLICATION SHALL BE GROUNDS FOR REVOCATION OF THE LICENSE ISSUED AND SHALL MAKE THE APPLICANT LIABLE TO PROSECUTION FOR PERJURY. PLEASE DO NOT LEAVE ANY AREAS UNANSWERED.

APPLICATION FEE: $700.00 (Non-Refundable).

Date of Application: 7-20-16

Property Owner Authorization

I (~~We~~) John T. Mitchell the

owner(~~s~~) of the following property located at: 184 N. Ave, Ste 105

Jonesboro, GA 30236

Tax Parcel Number: 13239B B005 2 Size of Property: _____

Located in Zoning District C-2 do hereby request permission for a

conditional use for the above described property under the Zoning Ordinance zoned for

the following purposes:

Business Office - like 75% of my other

Tenants

Property Owner Information

Name: JOHN T MITCHELL

Mailing Address: 186 N. Ave Ste 104

City: Jonesboro State: GA Zip: 30236

Phone: (Day) 678-794-3700 (Evening) 678-794-3700

Applicant's Information

(If Different from Owner's Information)

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: (Day) _____ (Evening) _____

Jonesboro Property Information

Existing Uses and Structures: RETAIL + BUSINESS + TOURISTING

Property address: 184 North Ave

Surrounding Uses and Structures: (See Official Zoning Map): _____

Surrounding Zoning:

North: _____ South: _____ East: _____ West: _____

Details of Proposed Use: BUSINESS OFFICE FOR CONSULTING FIRM

Public Utilities: ALL

Access, Traffic and Parking: Adequate

Special Physical Characteristics: _____

The City may require submission of additional information as may be useful in understanding the proposed use and development of the property.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION AND ALL ATTACHED INFORMATION IS TRUE AND CORRECT:

Date: 6-20-16 Signed: [signature]

Notary: Pat Daniel SEAL

PAT DANIEL NOTARY PUBLIC CLAYTON COUNTY, GA EXPIRES GEORGIA FEB. 03,2020

FOR OFFICE USE ONLY:

Date Received: 6/20/2016 **Received By:** R Clark

Fee Amount Enclosed: $ 700.00

Public Notice Sign Posted (Date) 08/24

Legal Ad Submitted (Date) _____

Legal Ad Published (Date) ~~08/30~~ 08/24 & 08/31

Date Approved: ____/____/20____

Date Denied ____/____/20____

Permit Issued ____/____/20____

Comment:

_____

_____

_____

CITY OF JONESBORO, GEORGIA COUNCIL
Agenda Item Summary

Agenda Item # PUBLIC HEARING – B

COUNCIL MEETING DATE
September 12, 2016

Requesting Agency (Initiator)
Office of the City Administrator

Sponsor(s)

Requested Action *(Identify appropriate Action or Motion, purpose, cost, timeframe, etc.)*
Council to consider Variance #16VAR-002 as requested by Tara Wrecker located at 9140 Turner Road to reduce the land buffer from 150' to 50'.

Requirement for Board Action *(Cite specific Council policy, statute or code requirement)*
Section 86-38

Is this Item Goal Related? *(If yes, describe how this action meets the specific Board Focus Area or Goal)*
Community Planning, Neighborhood and Business Revitalization

Summary & Background *(First sentence includes Agency recommendation. Provide an executive summary of the action that gives an overview of the relevant details for the item.)*

Tara Wrecker, located at 9140 Turner Road is applying to have their land-buffer variance reduced from 150' to 50'

History

Tara Wrecker was annexed into the City of Jonesboro in 2012. At the November 12, 2012 meeting, in which the annexation & rezoning was ratified by unanimous vote, the following conditions were set:

1. 150' buffer from back property line adjacent to the subdivision going west
2. On the west inside the buffer, Leland Cypress trees will be planted within 180 days
3. Code Enforcement to provide adequate screenage
4. Quarterly inspections by Code Enforcement
5. No permanent cars on site
6. No large trucks on City streets

Facts

Tara Wrecker sits on about 16.48 acres. Directly behind the subject site, is the Drakes Landing Subdivision. Several of the residences have spoken out regarding their dissatisfaction with any type of additional buffer being allowed. Upon review of the application, City Administrator Ricky Clark, Public Works Director Joe Nettleton & Code Enforcement Officer Derry Walker performed a site visit at both Tara Wrecker and the northern most house behind their site.

Staff Recommendation

- Staff feels that this request could cause an undue hardship on residents.
- Further, staff feels that if Tara Wrecker clears their land to the requested 150', it will give them ample space to expand their operation

Fiscal Impact *(Include projected cost, approved budget amount and account number, source of funds, and any future funding requirements.)*

$700- Application Fee

Exhibits Attached (Provide copies of originals, number exhibits consecutively, and label all exhibits in the upper right corner.)

- Variance Application - Tara Wrecker

FOLLOW-UP APPROVAL ACTION (City Clerk)

Typed Name and Title	Date		
Ricky Clark, City Administrator	September, 12, 2016	09/06/16	City Council OLD BUSINESS Next: 09/12/16
Signature	**City Clerk's Office**		

- Tara Wrecker Aerial Photo
- Tara Wrecker - Land Survey
- Tara Wrecker - 111212 minutes

Staff Recommendation *(Type Name, Title, Agency and Phone)*

No Decrease in Approve Land Buffer

CITY OF JONESBORO
124 North Avenue
Jonesboro, Georgia 30236
City Hall: (770) 478-3800
Fax: (770) 478-3775
www.jonesboroga.com

VARIANCE REQUEST

Section 86-38. of the Jonesboro Zoning Ordinance allows for the issuance of an Administrativ variances. An administrative variance may be granted up to ten percent of the standards of the abov referenced chapter. In addition to the Variance Request, please provide a Letter of Intent to includ each needed variance and the section of the City's code that pertains to each variance.

Please contact the Jonesboro City Hall (770) 478-3800 and speak with the City Clerk for furthe information.

Property Information:

Address: 9140 Turner Rd Jonesboro, GA 30936

Parcel Identification Number: See enclosed

Size: See enclosed

Owner: Foresta H Neace

Note: if applicant is not the owner, the applicant must provide written permission from the owner notarized, and owner's contact information. See Jonesboro City Hall staff to obtain permissibl document.

Applicant Information:

Applicant Name: Rhonda Lane

Mailing Address: P.O. Box 1199 Jonesboro, GA 30237

Email Address: twi.9140@gmail.com Telephone: 770-478-4170

PROJECT INFORMATION:

Section of Ordinance in which variance is needed: _____

Requesting Variance from: 150 ft buffer to: 50 ft buffer

Reason for Variance Request: requesting a 50 foot buffer

VARIANCE REQUEST

1. What are the extraordinary and exceptional conditions pertaining to the particular piece of property in question because of its size, shape or topography that are not applicable to other lands or structures in the same district.
   There are no extraordinary or exceptional conditions pertaining to this property.

2. List one or more unique characteristics that are generally not applicable to similarly situated properties.
   There is nothing unique with this property. It is similar or exact with adjacent properties

3. Provide a literal interpretation of the provisions of above referenced chapter and/or section that would deprive the applicant of rights commonly enjoyed by other properties of the district in which the property is located.
   Adjacent properties currenty have zero to fifty (0-50) foot buffers

4. Demonstrate how a variance prevents reasonable use of the property.
   Business located on said property is growing and it has become necessary to use said property. A 150 buffer would make useless nearly two acres.

5. Please explain the reasoning for the variance and state whether it is a result of the applicant.
It is unknown why an excessive 150 foot buffer was applied to this property.

6. Demonstrate how the variance is the only result to allow reasonable use of the property.
Business growth. In need to utilize said property

7. Will the granting of the requested variance be injurious to the public health, safety or welfare?
Absolutely not.

8. Will the requested variance be in harmony with the purpose and intent of the above referenced chapter and/or section?
Yes.

Foresta Neace	Foresta Neace
PRINT NAME	SIGNATURE
7-27-16	$ 700.00
DATE	FEE AMOUNT

FOR OFFICE USE ONLY:

Date Received: ____/____/20____

Information Reviewed By: _____

Actions Taken By: _____

Misc. Notes: _____

ATTACHMENT -1-

PROPERTY OWNER'S AUTHORIZATION

The Undersigned below, or as attached, is the owner of the property which is subject of this application. The undersigned does duly authorize the applicant named below to act as applicant in the pursuit of a variance for the property.

I swear that I am the owner of the property which is the subject matter of the attached application, as it is shown in the records of Clayton County, Georgia.

Rhonda Lane
PRINT NAME

Loresta Peace
SIGNATURE/DATE

NOTARY:

Tracie Williams
SIGNATURE/DATE
7-28-16

SEAL

New Search | Current Year Assessment Notice | Sales Data | Previous Parcel | Next Parcel

Clayton County Property Card For Year 2016

NEACE FORESTA HOPE
P O BOX 745
LOVEJOY, GA 30250

PARCEL ID . . 06032B A016
LOCATION . . 9140 TURNER RD
DEED YEAR 2009 BOOK 9769 PAGE 165

OWNER ID . . R404100

LEGAL DESC DISTRICT 4 JONESBORO
AREA. . . . . .222 C & I APPRAISER AREA 2
NBRHOOD

DESCRIPTION NOT IN SUBDIVISION - ALL UTILITIES
DESCRIPTION PAVED ROAD
ROAD FRONT . . . 550.0
PARCEL STATUS . . ACTIVE

SINGLE OFFICE

SALES HISTORY

DEED BOOK	PAGE	SALE DATE	SALES INSTRUMENT	DISQUALIFIED	SALE AMT	TRANS TYPE	DEED NAME
9769	165	11/23/09	QUIT CLAIM	MULTIPLE PROP/D		XFR	NEACE FORESTA HOPE
2357	237	5/31/95	WARRANTY DEED	ALTERED AFTER S	133,000	XFR	NEACE JACK
0038	422	1/01/43	WARRANTY DEED	.		XFR	MADDOX GEORGE

LAND SEGMENTS

LND#	ZONE	STRAT CODE	LAND TYPE/CODE	LAND QTY	LAND RATE	DPT%	SHP%	LOC%	SIZ%	OTH%	TOP%	TOT ADJ	CURRENT FMV
1	HI	I4	AC *OVR*	13.090	15,000.00	.00	.00	.00	.00	.00	.00	.00	196,500

USAGE . . CUP

OTHER ADJ - .00 .00 .00 .00

MAP ACRES . . 13.090

TOTAL LAND FMV 196,500

IMPROVEMENT # 1 MISC IMPR-Y

GROUND FLOOR AREA . .
STRAT I1

ACT/EFF YR/AGE . . 1965 1978 38
DESCRIPTION . . . .TARA WRECKER

	% COMP	SQ FOOTAGE	STORY	COST
BUILDINGS	100	1570.00		

FMV 131,500

TOTAL PARCEL VALUES	LAND / OVR	IMPROVEMENTS / OVR	TOTAL LAND/IMPROVE	2015 VALUE

New Search | Current Year Assessment Notice | Sales Data | Previous Parcel | Next Parcel

Clayton County Property Card For Year 2016

NEACE FORESTA HOPE
P O BOX 745
LOVEJOY, GA 30250

PARCEL ID . . 06032B A015
LOCATION . . TURNER RD
DEED YEAR 2009 BOOK 9769 PAGE 165

OWNER ID . . R404100

LEGAL DESC DISTRICT 4 JONESBORO
AREA. . . . . .222 C & I APPRAISER AREA 2
NBRHOOD

DESCRIPTION NOT IN SUBDIVISION - WATER/SEPTIC/ELEC/GAS
DESCRIPTION PAVED ROAD
ROAD FRONT . . . 225.0
PARCEL STATUS . . ACTIVE

IND 1 TO 5 ACRES

SALES HISTORY

DEED BOOK	PAGE	SALE DATE	SALES INSTRUMENT	DISQUALIFIED	SALE AMT	TRANS TYPE	DEED NAME
9769	165	11/23/09	QUIT CLAIM	MULTIPLE PROP/D		XFR	NEACE FORESTA HOPE
4385	104	5/02/00	WARRANTY DEED	QUALIFIED	63,000	XFR	NEACE JACK
1377	075	1/01/87	WARRANTY DEED	.		XFR	STRICKLAND JEFFREY L

LAND SEGMENTS

LND#	ZONE	STRAT CODE	LAND TYPE/CODE	LAND QTY	LAND RATE	DPT%	SHP%	LOC%	SIZ%	OTH%	TOP%	TOT ADJ	CURRENT FMV
1	HI	I3	AC *OVR*	4.250	15,000.00	.00	.00	.00	.00	.00	.00	.00	64,000

MAP ACRES . . 4.250

TOTAL LAND FMV 64,000

TOTAL PARCEL VALUES	LAND / OVR	IMPROVEMENTS / OVR	TOTAL LAND/IMPROVE	2015 VALUE
FMV	64,000	0	64,000	64,000
APV	64,000	0	64,000	64,000

New Search | Current Year Assessment Notice | Sales Data | Previous Parcel | Next Parcel

Clayton County Property Card For Year 2016

NEACE FORESTA HOPE
P O BOX 745
LOVEJOY, GA 30250

PARCEL ID . . 06032B A021
LOCATION . . TURNER RD R
DEED YEAR 2009 BOOK 9769 PAGE 165

OWNER ID . . R404100

LEGAL DESC

DISTRICT 4 JONESBORO
AREA. . . . . .222 C & I APPRAISER AREA 2
NBRHOOD

DESCRIPTION NOT IN SUBDIVISION - WATER/SEPTIC/ELEC/GAS
DESCRIPTION PAVED ROAD
PARCEL STATUS . . ACTIVE

VACANT RES/AG LAND

SALES HISTORY

DEED BOOK	PAGE	SALE DATE	SALES INSTRUMENT	DISQUALIFIED	SALE AMT	TRANS TYPE	DEED NAME
9769	165	11/23/09	QUIT CLAIM	MULTIPLE PROP/D		XFR	NEACE FORESTA HOPE
8776	381	6/29/06	WARRANTY DEED	QUALIFIED	15,000	XFR	NEACE JACK

LAND SEGMENTS

LND#	ZONE	STRAT CODE	LAND TYPE/CODE	LAND QTY	LAND RATE	DPT%	SHP%	LOC%	SIZ%	OTH%	TOP%	TOT ADJ	CURRENT FMV
1	RS110	C3	AC *OVR*	.796	15,000.00	.00	.00	.00	.00	.00	.00	.00	12,000

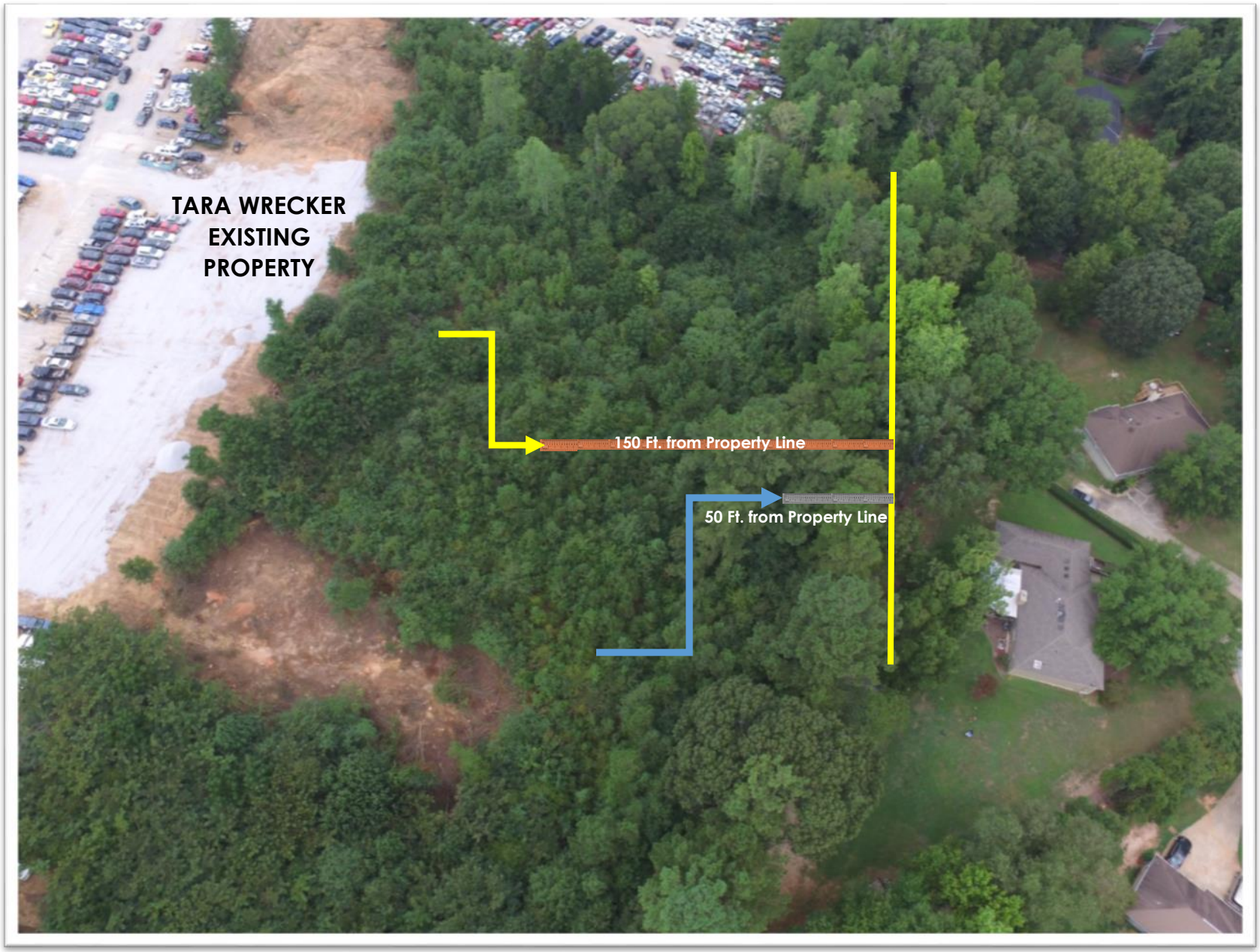
MAP ACRES . . .796

TOTAL LAND FMV 12,000

TOTAL PARCEL VALUES	LAND / OVR	IMPROVEMENTS / OVR	TOTAL LAND/IMPROVE	2015 VALUE
FMV	12,000	0	12,000	12,000
APV	12,000	0	12,000	12,000

Tara Wrecker Aerial Photo – August 29, 2016

= 14 ft.



LEGEND

LIMIT OF OWNERSHIP
COUNTY LINE
DISTRICT LINE
G.M.D.
RAILROAD RIGHT OF WAY
LAND LOT LINE
STREAM
CHURCH SCHOOL CEMETERY

THIS MAP WAS BEEN COMPILED FROM AN AERIAL SURVEY. IT IS TO BE USED FOR TAX PURPOSES ONLY. THE COUNTY AND/OR THE COMPANY ASSUMES NO RESPONSIBILITY FOR THE ACCURACY OF INFORMATION CONTAINED HEREIN.

TAX VALUATION MAP
CLAYTON COUNTY
GEORGIA

REVISIONS			
1.	5-2-88	DISTRICT	6
2.	5-25-90	G.M.D.	108
3.	5-10-96	LAND LOT	32
4.	5-8-97	BY	AD
5.	5-19-00	DATE	3-2

MAP NO.
6-32B

PHOTO: 260-187 SCALE: 1" = 100'

CITY OF JONESBORO
REGULAR MEETING MINUTES
NOVEMBER 12TH, 2012 – 7:00 p.m.

The City of Jonesboro Mayor and Council held the Regular meeting on Monday, November 12th, 2012. The meeting was held at 7:00 pm at the Jonesboro Police Department, 170 South Main Street, Jonesboro, Georgia.

Council Present: Joy Day, Mayor
Bobby Wiggins, Councilmember
Clarence Mann, Councilmember
Wallace Norrington, Councilmember
Pat Sebo, Councilmember
Joe Compton, Councilmember
Randy Segner, Councilmember

Staff Present: Joe Nettleton - Public Works Director, Chief Allen, Officer John Upole, Sgt. Jonathon Smallwood, Officer Jonathon Gray, Lt. Eric Bradshaw, Sgt. Brad Pair, Hydee Griffin – Administrative Assistant, Sandra Meyers – Finance Clerk and Janice Truhan – City Clerk.

Mayor Day called the meeting to order at 7:04 p.m. The invocation was given by Captain Christi Taylor – Salvation Army, and the Jonesboro Cub scouts Pack #543 was asked to come forward for the presentation of a City pin.

Public Comments were given by: Mrs. B. J. Burrell.

A formal presentation was given regarding Police department promotions, certificates were issued to Sgt. Brad Pair & Officer Jonathon Gray. Chief Allen presented an introduction of Officer John Upole, a new officer and Police Department Chaplin – Sam Waldrip. Additional certificates were issued to "Cert" graduates presented by Chief Allen, and Oath was read by Mayor Day.

Considered approval of minutes: Public Hearing of October 1, 2012 10:00 a.m., Public Hearing and Worksession meeting of October 1st, 2012 6:00 p.m., Public Hearing and Regular meeting of October 8th, 2012. Approved. [*Motion: Sebo, 2nd: Mann, Vote: Unanimous*].

Mayor Day called for motion to amend agenda to add item F1 – Bids for copier.

NEW BUSINESS (Items A-M):

A. Considered Proposed Ordinance related to Section 86 Zoning: Conditional Use – 90 days authorized for business turn around as presented by City Attorney Steve Fincher. Approved. [*Motion: Sebo, 2nd: Norrington, Vote: Unanimous*].

B. Considered annexation for 9140 Turner Road – PARCELS 06-032-B-A-016 – 13.090 ACRES; 06-032-B-A-015 – 2.72 ACRES; 06-032-B-A-021 - .796 ACRES; – PROPOSED ZONING M1 FORESTA H. NEACE APPLICANT AND PROPERTY OWNER. Approved. [*Motion: Segner, 2nd: Compton, Vote: Unanimous*].

C. Considered rezoning for 9140 Turner Road – PARCELS 06-032-B-A-016 – 13.090 ACRES; 06-032-B-A-015 – 2.72 ACRES; 06-032-B-A-021 - .796 ACRES; 06-032-B-A-015Z – 1.530 ACRES – PROPOSED ZONING M1 FORESTA H. NEACE APPLICANT AND PROPERTY OWNER. Approved with the following conditions: (1) - 150' buffer from back property line adjacent to the subdivision going west (2) – on the west inside the buffer Leland Cypress trees will be planted within 180 days (3) – Code Enforcement to provide adequate screenage (4) – quarterly inspections by Code Enforcement (5) – no permanent cars on site (6) – no large trucks on City streets according to the City Ordinance. [*Motion: Wiggins, 2nd: Norrington, Vote: Unanimous*].

D. Considered Soil and Erosion Ordinance. Approved. [*Motion: Segner, 2nd: Norrington, Vote: Unanimous*].

E. Considered purchase of two benches for Police Department lobby. Died due to lack of motion.

F. Considered bids for windows and kitchen door at City Hall. Approved. [*Motion: Mann, 2nd: Norrington, Vote:* Unanimous].

F1. Consider bids for Copiers. Postponed until November 26th, 2012 Called Meeting.

G. Considered new roof for Police Department. Approved. [*Motion: Compton, 2nd: Norrington, Vote: Unanimous*].

H. Considered bids for city storage building. Postponed until December 2012 Regular meeting.

I. Considered donation of Rose Garden from Ab Dickson. Approved. [*Motion: Sebo, 2nd: Mann, Vote: Unanimous*].

CITY OF JONESBORO, GEORGIA COUNCIL

Agenda Item Summary

Agenda Item # 10.C

PUBLIC HEARING – C

COUNCIL MEETING DATE
September 12, 2016

Requesting Agency (Initiator)
Office of the City Administrator

Sponsor(s)

Requested Action *(Identify appropriate Action or Motion, purpose, cost, timeframe, etc.)*
Council to consider adoption of the Official Zoning Map, as required by Section 86-74 of the Jonesboro Code of Ordinance.

Requirement for Board Action *(Cite specific Council policy, statute or code requirement)*
Sec. 86-74. – Amendments to the Official Zoning Map.

Is this Item Goal Related? *(If yes, describe how this action meets the specific Board Focus Area or Goal)*
Yes Economic Development

Summary & Background *(First sentence includes Agency recommendation. Provide an executive summary of the action that gives an overview of the relevant details for the item.)*

PURPOSE:

1. To consider the adoption of the Official Zoning Map, as required by Section 86-74 of the Jonesboro Code of Ordinance.

HISTORY:

1. At the last Council Meeting, City Council approved upzoning a parcel from H-1 to H-2. This map amendment simply formalizes that change.

Fiscal Impact *(Include projected cost, approved budget amount and account number, source of funds, and any future funding requirements.)*

Exhibits Attached (Provide copies of originals, number exhibits consecutively, and label all exhibits in the upper right corner.)

- Zoning Map - adopted 091216

Staff Recommendation *(Type Name, Title, Agency and Phone)*

To Approve the Adoption of the Official Zoning Map, as Required by Section 86-74 of the Jonesboro Code of Ordinance.

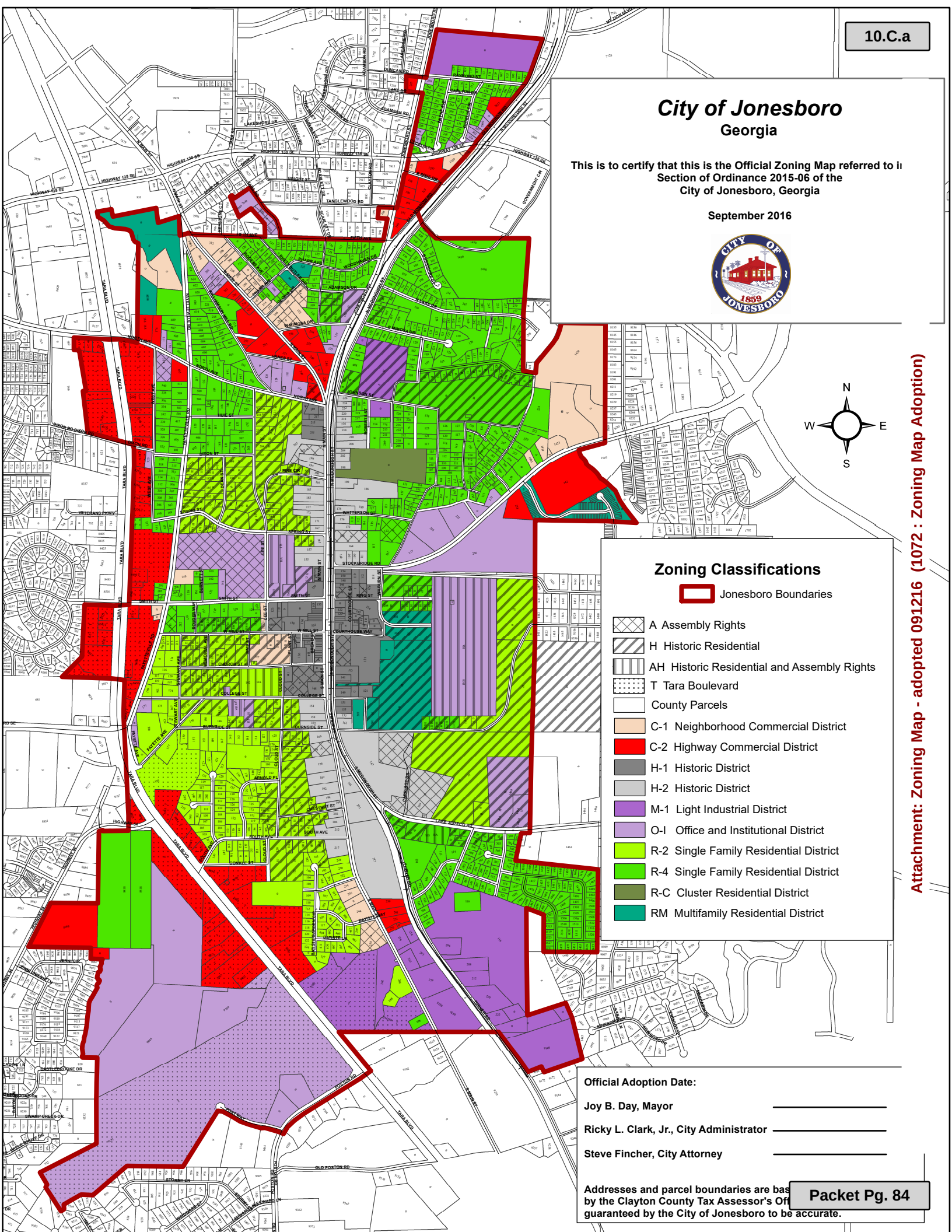
FOLLOW-UP APPROVAL ACTION (City Clerk)

Typed Name and Title	Date		
Ricky Clark, City Administrator	September, 12, 2016	09/06/16	City Council OLD BUSINESS Next: 09/12/16
Signature	**City Clerk's Office**		

City of Jonesboro
Georgia

This is to certify that this is the Official Zoning Map referred to i
Section of Ordinance 2015-06 of the
City of Jonesboro, Georgia

September 2016



Zoning Classifications

- Jonesboro Boundaries
- A Assembly Rights
- H Historic Residential
- AH Historic Residential and Assembly Rights
- T Tara Boulevard
- County Parcels
- C-1 Neighborhood Commercial District
- C-2 Highway Commercial District
- H-1 Historic District
- H-2 Historic District
- M-1 Light Industrial District
- O-I Office and Institutional District
- R-2 Single Family Residential District
- R-4 Single Family Residential District
- R-C Cluster Residential District
- RM Multifamily Residential District

Official Adoption Date:

Joy B. Day, Mayor _____

Ricky L. Clark, Jr., City Administrator _____

Steve Fincher, City Attorney _____

Addresses and parcel boundaries are bas
by the Clayton County Tax Assessor's Off
guaranteed by the City of Jonesboro to be accurate.

Attachment: Zoning Map - adopted 091216 (1072 : Zoning Map Adoption)