State of Illinois
Office of the Auditor of Public Accounts
Springfield 62706

MICHAEL J. HOWLETT
AUDITOR

July 28, 1972

PAYROLL BULLETIN
(8-72)

RUSH!

TO: All State Agencies and Departments
Attention: Payroll Clerks

SUBJECT: 4.5% Pay Increase

A 4.5% cost of living increase will be granted effective the September 1-15, 1972, pay period for various State Employees. The Auditor's office will supply pre-lists for the non-tape agencies receiving the increase if desired.

We ask that all State Agencies, Departments, Miscellaneous Boards and Miscellaneous Commissions not subject to the Personnel Code advise this office in writing whether or not you are to be granted the above 4.5% pay increase.

If you are granted the increase, please advise us by payroll code if you wish to receive prelists with the increase calculated.

For all Monthly and Semi-Monthly payrolls the 4.5% increase will be calculated on the rate of pay. Taxes, FICA and Retirement will be calculated on the new gross, voluntary deductions will be the same as the previous pay with the exception of optional State Life Insurance. If an employee does not have optional State Life Insurance, total deductions and net will be calculated on the pre-list.

It will be the responsibility of the payroll clerk to compute the units of Life Insurance and State paid Life amount on all employees. If an employee has optional State Life Insurance, the payroll clerk will also compute the deducted State Life, total deductions and net. These fields will be blank on the pre-lists.

For all Daily, Weekly, Bi-Weekly, and Hourly Payrolls the dollar fields and time worked field will be left blank except for voluntary deductions (excluding optional State Life). Computations will be made by payroll clerks.

IT IS IMPERATIVE THAT A REPLY BE RECEIVED IN THIS OFFICE PRIOR TO AUGUST 18TH IF YOU DESIRE A PRELIST WITH THE 4.5% INCREASE.

If no reply is received your prelist will be based on the rate of pay for the August 16-31 pay period.

Very truly yours,

Michael J. Howlett,
Auditor of Public Accounts

By: E.J.Pranke
Chief Accountant

EJP:MT:pc

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FORM W-4
U. S. Treasury Department
Internal Revenue Service

EMPLOYEE'S WITHHOLDING EXEMPTION CERTIFICATE

PLEASE TYPE

Voting County _____

Type Full Name _____ Social Security No. _____ Employee Serial _____

Legal Address _____ City _____ State _____ Date of Birth _____

Mailing Address if other than above _____ City _____ Zone _____ State _____

POS. CLASS | PAY CODE | DATE

Name Change ☐ Address Change ☐ Exemptions Change ☐

EMPLOYEE: File this form with your employer. Otherwise, he must withhold U. S. income tax from your wages without exemption.

EMPLOYER: Keep this certificate with your records. If the employee is believed to have claimed too many exemptions, the District Director should be so advised.

☐ Single ☐ Married

If you expect to owe more tax than will be withheld, you may either claim fewer or zero exemptions or ask for additional withholding on line 8.

1 Personal exemption for yourself. Write "1" if claimed . . . . .
2 If married, personal exemption for your wife (or husband) if not separately claimed by her (or him). Write "1" if claimed . . . . .
3 Special withholding allowance.[1] (See instruction 2.) Write "1" if claimed . . . . .
4 Exemptions for age and blindness (applicable only to you and your wife but not to dependents):
(a) If you or your wife will be 65 years of age or older at the end of the year, and you claim this exemption, write "1"; if both will be 65 or older, and you claim both of these exemptions, write "2" . . . . .
(b) If you or your wife are blind and you claim this exemption, write "1"; if both are blind, and you claim both exemptions, write "2" . . . . .
5 Exemptions for dependents. (Do not claim an exemption for a dependent unless you are qualified under instruction 5.) . . . . .
6 Additional withholding allowances for itemized deductions. See table on reverse . . . . .
7 Add the exemptions and allowances (if any) which you have claimed above and enter total . . . . .
8 Additional withholding per pay period under agreement with employer . . . . . $

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

(Date) _____, 19____ (Signed) _____

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PRINT FULL NAME

HOME ADDRESS

SOCIAL SECURITY NUMBER

EMPLOYEE IDENT. NUMBER

PAYCODE | VOTING COUNTY

Form IL-W-4

ILLINOIS DEPARTMENT OF REVENUE

EMPLOYEE'S ILLINOIS WITHHOLDING EXEMPTION CERTIFICATE

EMPLOYEE:
File this form with your employer. Otherwise he must withhold Illinois income tax from your wages without exemption.

EMPLOYER:
Keep this certificate with your records. If the employee is believed to have claimed too great an exemption, please inform the Illinois Dept. of Revenue.

HOW TO CLAIM YOUR ILLINOIS WITHHOLDING EXEMPTION

1. Write number of exemptions to which you are ENTITLED on your Federal Income Tax Return (Form 1040) . . . . . ☐
2. To claim your full Illinois exemption, enter the amount shown on Line 1. If you elect to reduce the amount of your Illinois exemption for purposes of withholding Illinois income tax, enter a lesser number. . . . . ☐

I CERTIFY that the withholding exemption claimed on this certificate does not exceed the amount to which I am entitled.

(DATE) _____, 19 ____ (SIGNED) _____

HACKETT CS00294

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PAYROLL DEDUCTION AUTHORIZATION FOR PURCHASE OF UNITED STATES SAVINGS BONDS STATE OF ILLINOIS

TO: The Hon. Michael J. Howlett
Auditor of Public Accounts
Room 201 State House, Springfield, Illinois

I AM PAID:
__ MONTHLY
__ SEMI-MONTHLY

I hereby authorize you to deduct the amount which I have checked on the reverse side of this card from my pay each pay period and to purchase United States Savings Bonds for me with the amounts deducted.

NAME: Mr. / Mrs. / Miss _____ DATE: _____
(Last) (First) (Middle)

STREET: _____ CITY: _____

SOCIAL SECURITY NUMBER: _____ STATE I. D. NUMBER: _____

AGENCY: _____ PAYROLL CODE: _____

__ Co-OWNER or __ BENEFICIARY Mr., Mrs., Miss: _____

NOTE TO EMPLOYEE: Complete 3 copies and submit to your employing agency if you work in a Code Department. Otherwise submit 2 copies.

SIGNATURE: _____

PLEASE DO NOT STAPLE OR BEND THIS CARD

(over)

3. Special Withholding Allowance - Each single person, and each married person whose spouse is not also employed, is entitled to one "special withholding allowance." This allowance may not be claimed by either husband or wife when both are employed or by any employee who has two or more concurrent jobs.

6. For Table - Refer to reverse side of Form W-4 (Rev. Dec. 1971). There is insufficient space to print the tables on this card.

FORM IL-W-4

NOTICE TO EMPLOYEE

1. Personal and dependency exemptions allowable for Federal Income Tax purposes may be used to compute your Illinois withholding exemption. Itemized deductions allowable for Federal Income Tax purposes are NOT allowable for Illinois Income Tax. DO NOT increase your Illinois exemption for itemized deductions for Federal Income Tax purposes.

2. You may file a new certificate at any time if the number of your exemptions for Federal Income Tax purposes INCREASES.

You MUST file a new certificate within 10 days if the exemption previously claimed by you DECREASES because of a reduction in the number of your exemptions for Federal Income Tax purposes.

The death of a wife or a dependent does not affect your withholding exemption until the next year, but requires the filing of a new certificate. If possible, file a new certificate by December 1 of the year in which the death occurs.

For further information, consult the Illinois Department of Revenue or your employer.

3. Do not claim an Illinois exemption in excess of the amount to which you are entitled. You may claim a lesser amount. Every individual whose annual tax can reasonably be expected to exceed the amount withheld and any credits allowed by more than $50.00, shall file with the Illinois Department of Revenue, a declaration of estimated tax.

4. Penalties: Penalties are imposed for willfully supplying false information or willful failure to supply information which would reduce the withholding exemption.

HACKETT 6S00296

PLEASE CHECK ONE -- MINIMUM DEDUCTION IS $3.75 PER PAY PERIOD

	PURCHASE PRICE	MATURITY VALUE	SAVINGS PER PAY	No. PAY PERIODS PER BOND
__	$ 18.75	$ 25.00	$ 3.75	5
__	$ 37.50	$ 50.00	$ 3.75	10
__	$ 37.50	$ 50.00	$ 7.50	5
__	$ 75.00	$100.00	$ 3.75	20
__	$ 75.00	$100.00	$ 5.00	15
__	$ 75.00	$100.00	$ 7.50	10
__	$ 75.00	$100.00	$15.00	5
__	$150.00	$200.00	$ 7.50	20
__	$150.00	$200.00	$15.00	10
__	$150.00	$200.00	$25.00	6
__	$375.00	$500.00	$37.50	10
__	$_____	$_____	$_____	__

The employee shall be solely responsible for maintaining a record of serial number, date of bond, and denomination of the bond.

Employee may fill in any purchase price indicated in chart with the corresponding maturity value, and indicate any amount of $3.75 or more to be saved per pay period, provided the amount selected will result in exactly equalling the purchase price of the bond selected.

NOTE: On Name of Owner, Co-owner or Beneficiary the purchaser may, if desired, designate an individual as co-owner or beneficiary to be named on the bond, but not both. Married women should use given name. (Mrs. Mary Smith, not Mrs. John Smith)

CHANGE AUTHORIZATION
FOR UNITED STATES SAVINGS BOND PURCHASE

4

I HEREBY REQUEST CHANGE IN MY PREVIOUS AUTHORIZATION FOR PURCHASE OF SAVINGS BONDS AS INDICATED BELOW:

☐ CHANGE OF ADDRESS
☐ CHANGE AMOUNT DEDUCTED
☐ TRANSFER FROM _____ TO _____
☐ CHANGE OF EMPLOYEE'S NAME
☐ CHANGE OF CO-OWNER OR BENEFICIARY

NAME: Mr. / Mrs. / Miss _____ (Last) (First) (Middle)

Effective Pay Period _____

STREET: _____ CITY: _____

SOCIAL SECURITY NUMBER _____ STATE I.D. NUMBER _____

AGENCY: _____ PAYROLL CODE: _____

☐ CO-OWNER OR ☐ BENEFICIARY MR.,MRS.,MISS _____

NOTE TO EMPLOYEE: Complete 3 copies and submit to employing dept. if you work in a code dept.,otherwise submit 2 copies. SIGNATURE: _____

PLEASE DO NOT STAPLE OR BEND THIS CARD (over)

PAYROLL DEDUCTION AUTHORIZATION
STATE OF ILLINOIS

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I AM PAID:
☐ MONTHLY
☐ SEMI-MONTHLY

AMT. TO BE DED. PER PAY $_____

EFFECTIVE PAY PERIOD _____

Please deduct from my warrant each pay period the amount shown above and turn over same to the Organization indicated for my credit. This deduction is to be in accordance with established rules of the State Salary and Annuity Withholding Act. (Please type or print)

DEDUCTION FOR: _____ (Organization) CODE # _____

NAME: _____ (Last) (First) (Middle) STREET _____ CITY _____

SOCIAL SECURITY NUMBER _____ STATE ID NUMBER _____

AGENCY: _____ PAYROLL CODE _____

NOTE TO EMPLOYEE: Complete 3 copies if you work in a Code Department, otherwise 2 copies and submit to your employing department.

SIGNED: _____

PLEASE DO NOT STAPLE OR BEND THIS CARD

STATE OF ILLINOIS
INSURANCE DEDUCTION AUTHORIZATION CARD

6

NAME _____ (LAST, FIRST, INITIAL) SOC. SEC. NO. _____

ADDRESS _____ (STREET)

_____ (CITY, STATE, ZIP)

EMPLOYER _____ (DEPT., DIV., DIST. OR INST.)

FOR USE OF PAYROLL OFFICE
STATE I.D. NO. _____
ORIGINAL PAYCODE _____

I hereby certify that I am enrolled in the State Employees Group Health and Life Insurance Program and for other insurance with _____ (CARRIER NAME), # _____ (CARRIER CODE). I authorize premium payment for elected coverages in the amount certified by the insurance carrier as the current rate of premium to be withheld from my pay in accordance with the State Salary and Annuity Withholding Act.

INITIAL PREMIUM PER PAY PERIOD _____

EFFECTIVE PAY PERIOD _____

EMPLOYEE'S SIGNATURE

PLEASE CHECK ONE -- MINIMUM DEDUCTION IS $3.75 PER PAY PERIOD

	PURCHASE PRICE	MATURITY VALUE	SAVINGS PER PAY	No. PAY PERIODS PER BOND
__	$ 18.75	$ 25.00	$ 3.75	5
__	$ 37.50	$ 50.00	$ 3.75	10
__	$ 37.50	$ 50.00	$ 7.50	5
__	$ 75.00	$100.00	$ 3.75	20
__	$ 75.00	$100.00	$ 5.00	15
__	$ 75.00	$100.00	$ 7.50	10
__	$ 75.00	$100.00	$15.00	5
__	$150.00	$200.00	$ 7.50	20
__	$150.00	$200.00	$15.00	10
__	$150.00	$200.00	$25.00	6
__	$375.00	$500.00	$37.50	10
__	$_____	$_____	$_____	__

The employee shall be solely responsible for maintaining a record of serial number, date of bond, and denomination of the bond.

Employee may fill in any purchase price indicated in chart with the corresponding maturity value, and indicate any amount of $3.75 or more to be saved per pay period, provided the amount selected will result in exactly equalling the purchase price of the bond selected.

NOTE: On Name of Owner, Co-owner or Beneficiary the purchaser may, if desired, designate an individual as co-owner or beneficiary to be named on the bond, but not both. Married women should use given name. (Mrs. Mary Smith, not Mrs. John Smith)

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REVOCATION OF PAYROLL DEDUCTION
State of Illinois

TO: Auditor of Public Accounts
Room 201 State House
Springfield, Illinois

EFFECTIVE PAY PERIOD _____

Please discontinue the deduction(s) as indicated on the reverse side of this card.

DEDUCTION FOR _____ (CARRIER NAME), # _____ (CARRIER CODE)

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

STREET _____ CITY _____

SOCIAL SECURITY NUMBER _____ STATE I.D. NUMBER _____

AGENCY _____ PAYROLL CODE _____

Note to Employee: Complete 4 copies

DP-9, 3.2f (6-72)

PLEASE DO NOT STAPLE OR BEND THIS CARD

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REVOCATION OF PAYROLL DEDUCTION
STATE OF ILLINOIS

TO: The Hon. Michael J. Howlett
Auditor of Public Accounts
Room 201 State House, Springfield, Illinois

EFFECTIVE PAY PERIOD _____

Please discontinue the following deduction which is now being made from my paycheck. This revocation is to be effective 30 calendar days from the date on this card.

DEDUCTION FOR: _____ (Organization) AMOUNT BEING DEDUCTED PER PAY: _____

NAME: _____ (Last) (First) (Middle) DATE: _____

STREET: _____ CITY: _____

SOCIAL SECURITY NUMBER: _____ STATE I. D. NUMBER: _____

AGENCY: _____ PAYROLL CODE: _____

NOTE TO EMPLOYEE: Complete 3 copies and submit to your employing agency if you work in a Code Department. Otherwise submit 2 copies.

SIGNED: _____

PLEASE DO NOT STAPLE OR BEND THIS CARD

REVOCATION OF PAYROLL DEDUCTION FOR INSURANCE

TO: The Auditor of Public Accounts

Please discontinue deducting from my pay only that portion of the premium designated below for the following coverages. (Check only those coverages being revoked.) I am paid ☐ Monthly ☐ Semi-Monthly

This revocation is to be effective with pay period beginning _____

		Cost			Cost
*All Optional Coverages	☐	$_____	Optional AD & D:		
Employee Hospital-Surgical	☐	_____	against basic	☐	$_____
Dependent Hospital-Surgical	☐	_____	against combined	☐	_____
Dependent Health (State Plan)	☐	_____	Spouse Optional Life	☐	_____
Sponsored Dependent Health	☐	_____	Children Optional Life	☐	_____
Employee Optional Life	☐	_____	_____	☐	_____

provided by _____ (CARRIER) _____ (CODE NO.) for which I have been paying by payroll deduction.

I hereby authorize the Auditor of Public Accounts to continue to deduct the balance, if any, of any premium payable to the above Carrier for any coverages, premium payment for which is not specifically revoked hereby.

Employee's Signature _____ Date _____

NOTE TO EMPLOYEE: Complete 4 copies

* Use in lieu of all other lines where all coverages are to be revoked. Use other lines where partial revocation is desired.