



Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No.1615-0047
Expires 07/31/2026

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

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 (if any)	Other Last Names Used (if any)
Address (Street Number and Name)			Apt. Number (if any)	City or Town	State ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address		Employee's Telephone Number
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.	Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):				
	<input type="checkbox"/> 1. A citizen of the United States				
	<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)				
	<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)				
<input type="checkbox"/> 4. A noncitizen (other than Item Numbers 2. and 3. above) authorized to work until (exp. date, if any) _____					
If you check Item Number 4. , enter one of these:					
USCIS A-Number		OR	Form I-94 Admission Number		OR
					Foreign Passport Number and Country of Issuance
Signature of Employee				Today's Date (mm/dd/yyyy)	

If a preparer and/or translator assisted you in completing Section 1, that person MUST complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign **Section 2** within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

	List A	O R	List B	AND	List C
Document Title 1					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 2 (if any)	Additional Information				
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
Document Title 3 (if any)					
Issuing Authority					
Document Number (if any)					
Expiration Date (if any)					
<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.					
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears 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.					First Day of Employment (mm/dd/yyyy):
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)
Employer's Business or Organization Name University of Idaho			Employer's Business or Organization Address, City or Town, State, ZIP Code 709 S Deakin St, Moscow, ID, 83844		

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.



Classification (please circle): Temporary Temp Faculty Faculty Classified Exempt Post-Doc
START DATE: _____ [] Background Check Completed
Department: _____
Supervisor: _____

Last Name _____ First Name _____ Middle Int. _____
Previous Names Used _____ Marital Status _____ Gender _____
Home Address _____ City _____ State _____ Zip _____
Phone _____ Email _____ Date of Birth _____
Social Security Number _____ Country of Citizenship _____

CURRENT / FORMER PERSI MEMBERS:
ALL POSITIONS:
Are you currently receiving PERSI retirement income? [] Yes [] No
FACULTY/EXEMPT/POST-DOC POSITIONS ONLY:
Are you vested in PERSI? (Vesting occurs after 5 years) [] Yes [] No
If Yes, would you like to continue your contributions to PERSI and waive enrollment in the ORP retirement plan? [] Yes [] No
If No, you will be enrolled in the ORP retirement plan and will need to contact PERSI to discuss options for your previous contributions (if applicable).

Please Note: Your campus mailing address and office phone number will be posted in the University of Idaho Online Directory. If you would like your information excluded from the directory, please contact Human Resources or your supervisor. You will need to request to be excluded again if you change positions at the university at any time.

- I have been informed and understand that Payroll and Benefit Services will send information regarding changes and updates to my benefits, meeting schedules and payroll information to my primary email account on file. (Not applicable to volunteers or affiliates)
I understand that my benefit information about my plan choices, dependents enrolled, cost, and qualifying life events may be found at my benefit portal in MyUI.
I understand that my University of Idaho demographic and payroll information is available to me and updateable by me through the MyUI portal.

Signature _____ Date _____

FSH 6240 and 6241 Required Disclosure of Conflicts

This Conflicts of Interest Disclosure form is to be signed by the employee and his/her supervisor after reviewing information on conflicts of interest and nepotism in the Faculty Staff Handbook 6240 and 6241. For each new employee, the signed Conflicts of Interest Disclosure form is to be returned to Human Resources for inclusion in the employee's file prior to the first week of work at the University. Each continuing University employee must complete this disclosure annually with his or her performance evaluation.

If you have a conflict to disclose, then you also will need to complete Form FSH 6240A. Likewise, if there is any change in your circumstance that may give rise to potential conflicts or eliminate potential conflicts previously disclosed, then you will need to complete Form FSH 6240A within 30 days of the change. University of Idaho FSH Policy 6240 Conflicts of Interest or Commitment is available at <http://www.webpages.uidaho.edu/fsh/6240.html> If you have any questions about the form or about specific potential or actual conflicts of interest, please contact your unit administrator or the Chair of the university's Ethical Guidance and Oversight Committee uifcoi@uidaho.edu. **Disclose outside employment for compensation of more than 20 hours/week by completing FORM 6240 B – Disclosure of Outside Employment or Consulting for Compensation.**

Please check one:

- I have reviewed [FSH 6240](#) and **DO NOT** have any conflicts of interest, conflicts of commitment or apparent conflicts to report.
- I have reviewed [FSH 6240](#) and **DO** have conflicts of interest, conflicts of commitment or apparent conflicts to report. Please submit a completed form FSH 6240A to your unit administrator, along with separate pages describing a plan to manage each conflict or apparent conflict.

Your signature below certifies that:

- you have reviewed FSH 6240 regarding disclosure of conflicts
- the information that you provide in this form regarding your disclosure of any conflict is accurate to the best of your knowledge as of the date of this document, and
- you commit to providing an update if a material change occurs in the information you have provided.

Employee Name: _____ Date: _____
Signature

Please Print (Last, First, MI): _____ Vandal #: _____

Immediate Supervisor: _____ Date: _____
Signature

Please Print (Last, First, MI): _____ Supervisor's Vandal #: _____

Intellectual Property Agreement for University of Idaho Employees

As an employee of the University of Idaho, I acknowledge that I am subject to and agree to abide by the policies of the Board of Regents of the University of Idaho, including but not limited to Idaho State Board of Education Governing Policies and Procedures, Section V. Financial Affairs, Subsection M. Intellectual Property, and University of Idaho policies, including but not limited to Faculty Staff Handbook 5300, Copyrights, Protectable Discoveries, and Other Intellectual Property Rights and 5700, Research Data, as these policies may be amended from time to time.

Pursuant to those policies I hereby agree to the following:

1. I will disclose to the University, through the Office of Technology Transfer, and do hereby assign to the University any and all Protectable Discoveries (*i.e.* “anything which might be protected by utility patent, plant patent, design patent, plant variety protection certificate, maskwork, or trade secret”) arising from my work and duties as an employee of the University, from my use of Board or University resources not openly available to the public, or otherwise subject to a claim of ownership under Board or University policies. I further agree to collaborate with the University in the assignment or confirmation of assignment, as required by the policies of the Board and the University, of all my right, title and interest in such Protectable Discoveries. I will also provide completed documents and fully participate in actions that allow the University to preserve, perfect, and protect its rights in Protectable Discoveries.
2. I acknowledge that University claims ownership of and do hereby assign to the University all my right, title and interest in copyrightable works that fall within the definition of “UI-Sponsored Materials,” as set forth in FSH 5300 B-2(b), or that are required for performance of University research and/or transfer of rights arising from University research to sponsors, as permitted under FSH 5300 E. I further agree to collaborate with the University in the assignment or confirmation of assignment, as required by the policies of the Board and the University, of all my right, title and interest in such works. I will also provide completed documents and fully participate in actions that allow the University to preserve, perfect, and protect its rights in such works.
3. I certify that I am under no consulting or other obligation to any third person, organization or corporation that is, or could be reasonably construed to be, in conflict with this agreement with respect to rights to Protectable Discoveries or copyrightable materials.
4. I will not enter into any agreement creating intellectual property obligations in conflict with this agreement or Board of Regents or University policies.

Signature

Printed Name

Date

Send original to Office of Technology Transfer, 875 Perimeter Dr., MS 3003, Morrill Hall 103, Moscow, ID 83844-3003; copy to HRS; copy to signer.

The University of Idaho is an Affirmative Action/Equal Opportunity Employer with a commitment to recruitment and retention of a diverse and inclusive campus community. Collection of the following information on sex, race/ethnicity, disability and veteran status is in compliance with Federal laws and regulations, executive orders and applicable State laws and regulations.

The information that you submit will remain **confidential, maintained separate from other personnel records** and be used by the University only for statistical and required reporting purposes. Completion of this form is **voluntary**; failure to provide this information will not adversely affect your employment.

Name: _____ **ID Number:** _____ **Date:** _____
Sex: Female Male

Race/Ethnicity:

What is your ethnicity?

Are you Hispanic or Latino? Yes No

What is your race? If you choose to voluntarily self-identify, please check one or more of the race or races with which you identify.

- American Indian or Alaska Native**
- Asian**
- Black or African American**
- Native Hawaiian or Other Pacific Islander**
- White**

Race/Ethnicity Definitions:

- **Hispanic/Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- **American Indian or Alaska Native** – A person having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.
- **Asian** – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American** – A person having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander** – A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White** – A person having origins in any of the original peoples of Europe, the Middle East or North Africa.

Veterans Status:

The University of Idaho is committed to equal opportunity and affirmative action in all aspects of employment for qualified protected veterans. We ask that you help us fulfill our commitments and to meet our obligations as a government contractor under the Vietnam Era Veterans’ Readjustment Assistance Act of 1974, as amended by the Jobs for Veterans Act of 2002, 38 U.S.C. 4212 (VEVRAA). VEVRAA requires us to take affirmative action to employ and advance in employment protected veterans.

While the University is required by VEVRAA to submit an annual report to the U. S. Department of Labor identifying the total number of employees who are “protected veterans” based on the categories listed below, submission of this information is voluntary on your part and refusal to provide it will not subject you to any adverse treatment. The information provided will be used only in a manner consistent with VEVRAA.

Protected Veteran classifications are defined as follows:

- **Disabled Veteran** – A veteran of the US military, ground, naval or air service who is entitled to compensation (or who but for the receipt of military retired pay would be entitled to compensation) under laws administered by the Secretary of Veterans Affairs; or a person who was discharged or released from active duty because of a service connected disability.
- **Recently Separated Veteran** – Any veteran during the three-year period beginning on the date of such veteran’s discharge or release from active duty in the US military, ground, naval, or air service.
- **Active duty wartime or campaign badge veteran** – A veteran who served on active duty in the US military, ground, naval or air service during a war, or in a campaign or expedition for which campaign badge has been authorized under the laws administered by the Department of Defense.
- **Armed Forces Service Medal Veteran** – A veteran who, while serving on active duty in the US military, ground, naval, or air service, participated in the United States military operation for which an Armed Forces service medal was awarded pursuant to Executive Order 12985.

Please check one of the boxes below:

- I am a protected veteran**
- I am NOT a protected veteran**
- I don’t wish to answer**

Reasonable Accommodation Notice: If you are disabled veteran and require a reasonable accommodation that would enable you to perform the essential functions of the job, including special equipment, changes in the physical layout of the job, changes in the way the job is customarily performed, provision of personal assistance services or other accommodations, please contact Human Resources at 208-885-3609 or hr@uidaho.edu.

Please return this form to the Office of Workforce Diversity
 Physical Address: Bruce Pitman Center, Room 41
 Mail: 875 Perimeter Dr. MS 4241, Moscow, ID 83844-4241
 Email: hrai@uidaho.edu

Voluntary Self-Identification of Disability

Form CC-305
Page 1 of 1

OMB Control Number 1250-0005
Expires 04/30/2026

Name: _____
Employee ID: _____
(if applicable)

Date: _____

Why are you being asked to complete this form?

We are a federal contractor or subcontractor. The law requires us to provide equal employment opportunity to qualified people with disabilities. We have a goal of having at least 7% of our workers as people with disabilities. The law says we must measure our progress towards this goal. To do this, we must ask applicants and employees if they have a disability or have ever had one. People can become disabled, so we need to ask this question at least every five years.

Completing this form is voluntary, and we hope that you will choose to do so. Your answer is confidential. No one who makes hiring decisions will see it. Your decision to complete the form and your answer will not harm you in any way. If you want to learn more about the law or this form, visit the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) website at www.dol.gov/ofccp.

How do you know if you have a disability?

A disability is a condition that substantially limits one or more of your "major life activities." If you have or have ever had such a condition, you are a person with a disability. **Disabilities include, but are not limited to:**

- Alcohol or other substance use disorder (not currently using drugs illegally)
- Autoimmune disorder, for example, lupus, fibromyalgia, rheumatoid arthritis, HIV/AIDS
- Blind or low vision
- Cancer (past or present)
- Cardiovascular or heart disease
- Celiac disease
- Cerebral palsy
- Deaf or serious difficulty hearing
- Diabetes
- Disfigurement, for example, disfigurement caused by burns, wounds, accidents, or congenital disorders
- Epilepsy or other seizure disorder
- Gastrointestinal disorders, for example, Crohn's Disease, irritable bowel syndrome
- Intellectual or developmental disability
- Mental health conditions, for example, depression, bipolar disorder, anxiety disorder, schizophrenia, PTSD
- Missing limbs or partially missing limbs
- Mobility impairment, benefiting from the use of a wheelchair, scooter, walker, leg brace(s) and/or other supports
- Nervous system condition, for example, migraine headaches, Parkinson's disease, multiple sclerosis (MS)
- Neurodivergence, for example, attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder, dyslexia, dyspraxia, other learning disabilities
- Partial or complete paralysis (any cause)
- Pulmonary or respiratory conditions, for example, tuberculosis, asthma, emphysema
- Short stature (dwarfism)
- Traumatic brain injury

Please check one of the boxes below:

- Yes, I have a disability, or have had one in the past
- No, I do not have a disability and have not had one in the past
- I do not want to answer

PUBLIC BURDEN STATEMENT: According to the Paperwork Reduction Act of 1995 no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. This survey should take about 5 minutes to complete.

For Employer Use Only

Employers may modify this section of the form as needed for recordkeeping purposes.

For example:

Job Title: _____ Date of Hire: _____



Beneficiary Designation

Purpose of the Form

- Use this form to designate beneficiaries to receive your PERSI Base Plan and Choice 401(k) Plan death benefits.
- Note:** For purposes of your death benefits, the designation(s) in this form supersede all other arrangements, and will be honored regardless of those arrangements, including a last will and testament or trust document. However, death benefits are still subject to community property law.

Instructions

- Read **About Form RS115**, attached.
- Note:** If your address has changed, you must submit form RS110, *Member Mailing Address Change*, with this form.

Member Social Security Number	Member PERSI ID Number*

* A PERSI ID is only required for members with multiple PERSI accounts.

Member Information			
Name – First, Middle, Last			
Mailing Address	Street or P.O. Box		
	City	State	Zip Code
Daytime Phone Number (include area code)		Email Address	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married

Primary Beneficiary or Beneficiaries					
Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
				.0%	<input type="checkbox"/> Check this box and go to page 2.
				.0%	<input type="checkbox"/> Check this box and go to page 2.
				.0%	<input type="checkbox"/> Check this box and go to page 2.
				.0%	<input type="checkbox"/> Check this box and go to page 2.

Secondary Beneficiary or Beneficiaries					
Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
				.0%	<input type="checkbox"/> Check this box and go to page 2.
				.0%	<input type="checkbox"/> Check this box and go to page 2.
				.0%	<input type="checkbox"/> Check this box and go to page 2.
				.0%	<input type="checkbox"/> Check this box and go to page 2.

Member Acknowledgment	
I understand the instructions and information under "About Form RS115." I revoke all previous PERSI beneficiary designations and request that any PERSI benefits payable after my death be made as indicated herein. I may change this designation by filing a new form. This designation applies to my PERSI Base and Choice 401(k) Plan accounts.	
Signature	Date – mm/dd/yyyy



Beneficiary Designation (continued)

Member Name – First, Middle, Last	Social Security Number
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Custodian Nominations for Minor Beneficiaries under the Idaho Uniform Transfers to Minors Act

- Use this section to nominate custodians and substitute custodians for minor beneficiaries under the Idaho Uniform Transfers to Minors Act. Attach a copy of this page if nominating custodians for more than 4 minor beneficiaries.

Instructions

- Write the minor beneficiary’s name in the top box.
- Write the custodian’s name, Social Security number, address, and telephone number in the appropriate boxes. You can nominate a substitute custodian to serve in the event the nominated custodian is unable. List each minor beneficiary separately, even if you are nominating the same custodian for all minor beneficiaries.

Minor Beneficiary Name:			
Custodian Information		Substitute Information	
Name:		Name:	
SSN:		SSN:	
Address:		Address:	
City, St, Zip:		City, St, Zip:	
Telephone:		Telephone:	

Minor Beneficiary Name:			
Custodian Information		Substitute Information	
Name:		Name:	
SSN:		SSN:	
Address:		Address:	
City, St, Zip:		City, St, Zip:	
Telephone:		Telephone:	

Minor Beneficiary Name:			
Custodian Information		Substitute Information	
Name:		Name:	
SSN:		SSN:	
Address:		Address:	
City, St, Zip:		City, St, Zip:	
Telephone:		Telephone:	

Minor Beneficiary Name:			
Custodian Information		Substitute Information	
Name:		Name:	
SSN:		SSN:	
Address:		Address:	
City, St, Zip:		City, St, Zip:	
Telephone:		Telephone:	

About Form RS115

Instructions

- 1 Complete the form and sign in blue or black ink.
 - If your address has changed, you must submit form RS110, *Member Mailing Address Change*, with this form.
- 2 Use whole percentages only.
- 3 If more space is needed, attach an additional signed and dated sheet of paper.
- 4 If any designated beneficiary is a minor, complete page 2 if you choose to nominate an adult custodian to receive the funds for the minor. PERSI cannot pay a death benefit directly to a minor beneficiary.
- 5 Send the form to PERSI.

Note: The form is not valid unless signed, dated, and on file with PERSI.

Types of Beneficiaries

- **Primary beneficiary or beneficiaries.** The first person or persons to receive death benefits when you die. If you select one person only, he or she receives 100% of the benefits.
- **Secondary beneficiary or beneficiaries.** Person or persons to receive death benefits if no primary beneficiary or beneficiaries are alive when you die.
- **Default beneficiary.** If PERSI does not have a beneficiary designation on file, death benefits are paid by law to the following: (1) To your surviving spouse. (2) If you have no surviving spouse, to your estate. If you agree with this default distribution and you have not previously submitted a beneficiary designation form, you do not need to designate a beneficiary or submit this form. However, payment of death benefits could be delayed if PERSI has no designation on file.

Notes About Designating Beneficiaries

- For purposes of your death benefits, the designation(s) in this form supersede all other arrangements, and will be honored regardless of those arrangements, including a last will and testament or trust document. However, death benefits are still subject to community property law.
- Percentages must be in whole numbers. Do **not** use partial numbers. For example, use 33% not 33⅓%.
- Choose your beneficiaries carefully. Your PERSI funds might be your largest financial asset.
- If you select two or more people as primary or secondary beneficiaries, indicate what percentage each is to receive (the percentages must equal 100%).
- You must list your children separately.
- If you are designating one or more minors as beneficiary, you should specify how you want your death benefit transferred if you die before the beneficiary reaches legal age of majority. PERSI cannot disburse the money to a minor, so if you don't nominate a custodian on this form, a court may have to appoint an adult to serve as conservator of the funds. This form provides an easy and inexpensive way to transfer death benefits to a minor through the Idaho Uniform Transfers to Minors Act (UTMA). This law enables you to nominate a custodian, and substitute custodian, for your minor beneficiary, and authorizes PERSI to pay your death benefit to the custodian. To nominate a custodian for a minor beneficiary, fill out page 2 of this form.
- If you use the UTMA to nominate a custodian for your minor beneficiary, be aware that the legal age of majority under the UTMA is 21, even though the statutory age of majority in Idaho is 18. If you die before your beneficiary is 21 years of age, the money will go to and remain in the custodian's care until the beneficiary reaches age 21.
- Always provide full names (Mary Elizabeth Smith, **not** Mary Smith). For a married woman, use her full name (Mary Elizabeth Smith, **not** Mrs. Bob Smith). Include the relationship to you.
- This beneficiary designation is for PERSI Base Plan and Choice 401(k) Plan death benefits **only**. Any designations you make for a will or an insurance policy do not substitute for the PERSI beneficiary designation.
- Submit a new *Beneficiary Designation* (RS115) to PERSI if your marital status changes.
- Complete a *Member Name Change* (RS111) if your name changes. If you are an active member, (working for a PERSI employer and making contributions) give the form to your payroll clerk. If not, send the form to PERSI.
- You can change your designations at any time by submitting a new *Beneficiary Designation* (RS115) to PERSI.
- If you make an error, initial and date any corrections.

Minor Children, Trusts, Wills, and Charities as Beneficiaries

- **Minor children.** To designate a minor child as a primary or secondary beneficiary, you should consider transferring the money to a custodian for the child under the provisions of the Idaho Uniform Transfers to Minors Act (UTMA). Using PERSI form RS115 page 2 meets the UTMA requirements.
- **Trusts.** If you want to designate your Living Trust, show the date of the trust agreement and the name(s) of the Trustee(s). If a bank or trust company is the Trustee, attach a separate document containing the Trustee's address. Provide PERSI with a copy of the trust's registration, if available. The trust must have a tax ID number.
- **Wills.** Write "the Executor of my Estate" or "the Administrator of my Estate" to designate your estate as beneficiary. Do not name the executor, because the executor will be appointed later by the court.
- **Charities.** You can name a specific charity as beneficiary. For more information about payment of death benefits to charities, PERSI recommends that you consult with a qualified attorney.

Example 1

Primary Beneficiary or Beneficiaries					
Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
Phillip Lee Thompson	000-01-0011	07-11-1937	Spouse	100.0%	<input type="checkbox"/> Check this box and go to page 2.
					<input type="checkbox"/> Check this box and go to page 2.

Secondary Beneficiary or Beneficiaries					
Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
John Allen Smith	000-08-0025	01-09-1997	Son	80.0%	<input type="checkbox"/> Check this box and go to page 2.
Rebecca Joan Smith	000-02-0220	01-02-1958	Sister	20.0%	<input type="checkbox"/> Check this box and go to page 2.

Example 2

Primary Beneficiary or Beneficiaries					
Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
Sally Jones	000-03-0033	08-21-1994	Daughter	34.0%	<input checked="" type="checkbox"/> Check this box and go to page 2.
Alice Jones	000-04-0044	11-14-1991	Daughter	33.0%	<input checked="" type="checkbox"/> Check this box and go to page 2.
Andrew Jones	000-05-0055	02-29-1987	Son	33.0%	<input type="checkbox"/> Check this box and go to page 2.

Secondary Beneficiary or Beneficiaries					
Name	Social Security or Tax ID Number	Date of Birth	Relationship to You	Benefit %	Nominate a custodian under the Idaho UTMA
The administrator of my estate			Estate	100.0%	<input type="checkbox"/> Check this box and go to page 2.
					<input type="checkbox"/> Check this box and go to page 2.