Diocese of Yakima Salary Reduction Plan
2020 Election Form/Salary Reduction Agreement

Hire Date:______/_____/_______ Department:____ ☐ Male ☐ Female

Employee Name: Last______________________________ First____________________ MI_____ Soc. Sec.______/____/_____

Employee Home Address:____City______________State_____ Zip__________

Marital Status: ☐ Married ☐ Single Birth date______/____/______ Home Phone: ______________________________

(HR to Complete) Effective Date ________________ Salary __________________ ☐ Key Employee ☐ Highly Compensated
HOURLY EE SALARIED EE Number of FSA Pay Periods Per Year ______ Start Date of Pay Period for New Plan Year: ___________

For Plan Year January 1, 2020 through December 31, 2020

Benefit Election Options	Election	Salary Reduction Amount	***Benefits Office Use Only***
OPTION I—Premium Payment Component *The Group Insurance Premiums you pay through payroll deductions*	**Automatic**	**The amount necessary to pay for your share of all group insurance premiums.**	
OPTION II—Health FSA Component *Maximum of $2,700 (subject to change)* **IRS Maximum Change Acceptance** *If IRS Maximum changes to $2,750, do you wish to increase your election to the new IRS Maximum?*	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**	$________________________ *per pay period*	$______________ Annual Election
OPTION III—Dependent Care FSA Component *Maximum of* ***$5,000 for the 2020 Calendar Year*** *(Please review your FACT sheet for further guidance on the maximum contribution you may be eligible for.)*	☐ **Yes** ☐ **No**	$________________________ *per pay period*	$______________ Annual Election

Elections Irrevocable Unless Exception Applies

I understand that I cannot change or revoke this Agreement as of any date prior to the next January 1, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Election Event, as described in the Plan.

Additional Terms

- I agree that my Compensation will be reduced by the amount of my required contribution for the Benefits that I have elected under the Plan and that such Salary Reductions will continue for each pay period until this Agreement is amended or terminated. I understand that my contribution for the health insurance benefits may be automatically increased or decreased for changes by the Plan Administrator. I also understand the following:
- Signing this Agreement does not initiate my coverage under the health insurance policies. I must complete a separate health insurance enrollment form to start my health insurance coverage.
- Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
- If any unused amounts remain in my Health FSA and DCAP Accounts after reimbursing my eligible expenses incurred during the Plan Year and subsequent grace period (if any), these amounts will be forfeited.
- Prior to December 31 of each year I will be offered the opportunity again to elect Premium Payment, Health FSA and DCAP coverage for the following Plan Year. If I do not complete and return a new Agreement at that time, then I will be treated as having elected to waive all pre-tax benefits under the Health FSA and DCAP Components of the Flexible Spending Account Plan and my pre-tax coverage will cease at the end of the Plan Year (December 31).

Waiver of Pre-Tax Benefits Under the Salary Reduction Plan; Election of After-Tax Benefits
(Check box if applicable; do not check this box if you have checked one or more boxes in the section above)

☐ I elect to waive all pre-tax benefits under the Plan. I understand that if I have enrolled for health insurance coverage on a separate benefit enrollment form, I will pay my share of the contribution with after-tax payroll deductions. Except for a Change in Election Event for the applicable Benefit(s) (as described below), I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverage(s) shall be outside the Plan.

I have read and agree to the terms of participation and to any applicable certifications set forth in this Agreement. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Election Form/Salary Reduction Agreement, is hereby revoked.

Employee's Signature: ____ **Date:** ______________________________

Plan Administrator's Signature: ____ **Date:** ______________________________

Administered by: **TPSC Benefits**
P.O. BOX 1894, Tacoma, WA 98401-1894
(253) 564-5611, Ext. 210 or 1(800) 426-9786, Ext. 210