DIOCESE OF YAKIMA

PREMIUM ONLY PLAN

ELECTION FORM AND COMPENSATION REDUCTION AGREEMENT

Medical, Dental, Voluntary Life & Disability - Plan Year 11/1/18-10/31/19

Flexible Spending FSA (Health and/or Dependent Care) & Voluntary Vision – Plan Year 1/1/19-12/31/19

NAME OF WORK LOCATION:____

NAME:______________________________________ S.S.#______________________

ADDRESS:____

I elect to participate in the I.R.C. Section 125 plan for: **Circle a number below & fill in the blanks if necessary)**

1. **A full Plan year - use for making an election during the annual enrollment period.** Full plan year is from November 1, 2018 – October 31, 2019 for Medical, Dental and Voluntary Products; and January 1, 2019 through December 31, 2019 for Flexible Spending FSA (Health and/or Dependent Care).

2. **A partial Plan year - use if hired or rehired during a Plan year.**
My date of hire is_______________________________,201__. My coverage effective date will be the first of the month coinciding with or following my date of hire. My contributions will continue through the end of the Plan Year as outlined above and in the Summary Plan Description.

3. **Please fill in below, the amount you pay, next to the election/elections that you participate in :**
This election is for: **Post-tax contribution*

Nov 1, 2018 – Oct 31, 2019 Plan Year:

Employee Medical Only $________ Employee Dental Only $________
Employee Medical/Dental $________ Dependent Medical Only $________
Dependent Medical/Dental $________ Dependent Dental Only $________
*Voluntary Life, AD&D, STD and/or LTD Options $________

Jan 1, 2019 – Dec 31, 2019 Plan Year:

Flexible Spending (FSA) - Health $________ Flexible Spending (FSA) - Dependent Care $________
Voluntary Vision Care $________

Health Insurance Premium Plan

The amount of compensation reduction shall be equal to the cost of the Company Health Insurance and coverage that I have selected which is in excess of the amount that the Company will contribute on my behalf toward the cost of such insurance.

My employer and I hereby agree that my cash compensation will be reduced by the amount set forth above, in equal installments per pay period or per month as defined by the Employer, and that if the cost of the insurance I have selected increases, my Employer will automatically increase my compensation reduction. I further understand that this reduction may correspondingly reduce future social security benefits.

I understand that my compensation reduction will be credited to a Health Insurance Premium Payment Account and my Employer will pay my portion of Health Insurance Premiums, as due, from this account.

This agreement is subject to the terms of the Employer's I.R.C. Section 125 Plan as in effect, shall be governed by and construed in accordance with the laws of Washington, and revokes any prior Election and Compensation Reduction Agreement I may have signed relating to the Employer's I.R.C. Section 125 Plan.

Employee Signature:____ Date:________________

ACCEPTED AND AGREED TO by the **Employer:** Bookkeeper, Secretary, Principal, Pastor

Employer Signature:____ Date:________________

Please return this form to the Diocese of Yakima, Attn: Parish Payroll Administrator

01-01-2018