PLEASE COMPLETE THIS FORM ONLY IF YOU ELECT TO PARTICIPATE IN THE MEDICAL OR DEPENDENT REIMBURSEMENT PLANS OR INSURANCE PREMIUM PAYMENT WAIVER.

Archdiocese of St Louis
Employee Flexible Benefits Plan Election Form

Please check one of the following:

☐ Open Enrollment for New Fiscal Plan Year (July 1, 2013 through June 30, 2014)
☐ New Employee (Fiscal Plan Year July 1, 2013 through June 30, 2014)
☐ Change of Contribution/Payroll Deduction
Event/Reason for Change: _____
Date of first paycheck affected:_____
(Indicate New Annual Election and per Paycheck Contribution Amount in Section 2)

Shaded Area Completed by Employer
Parish/Agency Employer Number:
Effective Date:

1. Employee Information

Last Name First Name Middle Initial		Month Day Year Date of Birth / /	Sex Male ☐ Female ☐
Home Mailing Address		Social Security Number - -	
City State Zip	Marital Status Married ☐ Unmarried ☐	Date Employed / /	
Parish/Agency Employer Name		Home Telephone No. ( )	

2. Medical Reimbursement Plan

MEDICAL REIMBURSEMENT ACCOUNT PLAN (Do not include employee health insurance premium contributions)

Maximum Allowable Account amount is: **$2,500 per Plan Year**

Payroll Deduction Amount $ _____ ÷ _____ = $ _____

Total Annual Before-Tax Dollars Contribution | Number of Payroll Periods Remaining in Fiscal Plan Year | Contribution per Paycheck

Dependent Care Reimbursement Plan

DEPENDENT CARE REIMBURSEMENT ACCOUNT PLAN

Maximum Allowable Account amount if Single, Head Of Household Or Married, Filing Joint Return: $5,000 per Plan Year

Maximum Allowable Account amount if Married, Filing Separate Return: $2,500 per Plan Year

Payroll Deduction Amount: $ _____ ÷ _____ = $ _____

Total Annual Before-Tax Dollars Contribution | Number of Payroll Periods Remaining in Fiscal Plan Year | Contribution per Paycheck

3. Designate Your Beneficiary

I hereby make the following beneficiary designation. In the event of my death, checks payable out of my flexible benefits spending account should be made payable to the undersigned.

Beneficiary_____ Relationship _____

4. Employee Health Insurance Premium Payment Plan Waiver

Group sponsored insurance premiums may be funded with pre-tax dollars. Your health insurance contributions will be automatically withheld from your pay before taxes are applied (which creates tax savings) unless you choose to waive. If you choose to waive, your health insurance contributions will be withheld from your pay after taxes are applied (with no affect on payroll taxes).

By not electing the waiver, you are authorizing your employer to reduce your salary before taxes by the employee contribution amount, as designated by your employer, to cover the premium for your employer sponsored health insurance plans in which you have elected to enroll.

☐ **Waive**, deduct my employee health insurance plan contributions **after applying taxes**, as designated by my employer, to cover the premium for employer sponsored health insurance plans in which I have elected to enroll.

5. Read and Sign

My signature on this form certifies that I have received and read the printed material explaining my employer's flexible benefits program. I understand that by signing and submitting this form I am making a binding decision which cannot be changed or revoked during the plan year unless there is a change in my family status (e.g., marriage, divorce, birth, or adoption of a child, or termination of spouse's employment). I understand that all unused amounts at the end of the plan year will be forfeited to the employer. I understand that any amounts designated for dependent care reimbursement cannot be used to claim a dependent care income tax credit. I understand any medical reimbursements I receive may not be included as a deduction on my income tax return. I am only requesting reimbursement of any medical or dependent care expenses to the extent they will not be paid or reimbursed under any other plan. I authorize my employer to reduce my pay by the amount I have indicated above.

Employee Signature_____ **Date** _____