Annual Salary Reduction Agreement for MCC Flexible Benefit Plan and Post-Tax Plans

PLEASE NOTE: This form is provided by Michigan Catholic Conference (MCC) for employers' internal use in administering benefits in accordance with MCC benefit plan rules. Please retain completed forms for your records. **Do not submit to MCC.**

Employee Information *All sections to be completed in full. You must also complete benefit enrollment using MCC Employee Self-Serve or by contacting MCC.*

Full name *Last, first, and middle*	SSN *###-##-####*
Address *Street address or PO box, city, state, and zip code*	Phone *(###) ###-####*

Employer Information *All sections to be completed in full.*

Unit name	Unit number *####*

Employee Per Pay Period Deductions *'Voluntary' and 'Child Voluntary' Life Insurance are not part of the MCC Flexible Benefit Plan—**deductions are post-tax**. The elections below **must** match benefit elections made using MCC Employee Self-Serve or by contacting MCC. Please refer to your Benefit Confirmation Statement and your Employer Premium Sharing amount to properly complete this section.*

Medical Plan	Coverage: ☐ Waive ☐ Employee ☐ Employee + One ☐ Employee + Family	Plan: ☐ BCBSM PPO1 ☐ BCBSM PPO2 ☐ BCBSM PPO-HD ☐ BCN BEP	Per pay period deduction $
Dental Plan	Coverage: ☐ Waive ☐ Employee ☐ Employee + One ☐ Employee + Family		Per pay period deduction $
Vision Plan	Coverage: ☐ Waive ☐ Employee ☐ Employee + One ☐ Employee + Family		Per pay period deduction $
Voluntary Life Insurance		Coverage amount $	Per pay period deduction $
Child Voluntary Life Insurance		Coverage amount $	Per pay period deduction $
Health Care Flexible Spending Account (aka Medical Expense Reimbursement Benefit)		Annual amount $	Per pay period deduction $
Health Savings Account (HSA)		Annual amount $	Per pay period deduction $
Dependent Care Flexible Spending Account (aka Dependent Care Assistance Benefit)		Annual amount $	Per pay period deduction $
Limited Purpose Flexible Spending Account (LPFSA)		Annual amount $	Per pay period deduction $
		Plan year *YYYY*	Total per pay period $ 0.00

Employee Signature *You must sign, date, and **submit this form to your employer** for it to be valid.*

☐ I confirm my enrollment in the MCC benefit plans as indicated above and I have been provided with my contribution share for the coverage selected. I authorize salary reductions in the amount of premiums being charged for the coverage selected above. **I understand that: 1)** The amount of my compensation reduction will be credited to a bookkeeping account of the Employer to pay for the employee share of benefits I have elected to receive. **2)** I cannot change or revoke this compensation reduction during the Plan Year unless I have a qualified change of status as defined by the Plan and as allowed by the underlying benefit plan. **3)** Health Care FSA dollars are to be used consistent with the teachings of the Catholic Church. **4)** If my required contributions to pay premiums for the elected benefits are increased or decreased while this agreement remains in effect, my compensation reductions will automatically be adjusted to reflect that increase or decrease. **5)** The Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he/she believes it advisable to satisfy certain provisions of the Internal Revenue Code or other applicable law. **6)** The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefits programs maintained by my employer and any other reduction required or permitted by law. **7)** Pre-tax contributions are not subject to state or federal income or Social Security ("FICA") taxes. This could result in a reduction in the Social Security benefits I receive at retirement if I earn less than the annual FICA "taxable wage base". **8)** Prior to the first day of each Plan Year I will be offered the opportunity to make a new benefit election for the coming Plan Year. If I do not complete and return a new enrollment form at that time, I will be treated as having elected to continue this benefit election for the new Plan Year, **except** for Flexible Spending Accounts which requires an active enrollment each year. In addition, this compensation reduction agreement will continue by its terms in the amount of the required contribution for the benefit option for the new Plan Year. **9)** This Agreement is subject to the terms of the Michigan Catholic Conference Section 125 cafeteria plan, as amended from time to time in effect, shall be governed by and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election and compensation reduction agreement relating to such plan.

Signature	Date *MM/DD/YYYY*

For employer use only—do not submit this form to MCC.