The Corinthian Plan
Together, providing health care for pastors and church workers

Election Form - With a Health Savings Account

Section 125 Cafeteria Plan for Mennonite Church USA

Plan year: Jan. 1 to Dec. 31

If you have any questions about how to complete this form, please contact Deana Roth at Everence, (800) 222-5054, ext. 3264.

Congregation or office _____

Employee name _____ Social Security number _____
First middle last

Address _____
Street City State ZIP code

Birth date _____

Please complete Part A if you are choosing to participate or Part B if you are declining to participate.

Part A – To be completed by employee if choosing to participate

Complete each of the sections you are selecting. **Please note that each section is calculated separately, and you will not have any amount listed under premium expense.**

1. Employee health savings account contributions

This is where you authorize pretax salary reduction for your contributions to your health savings account. Please note that any amounts you have remaining in your account at the end of the year will carry over to the next year. And, you can change your election later at any time by completing and returning a *Change Form* to your employer.

The maximum annual HSA contribution allowed is the amount for single coverage and family coverage set by the IRS for this tax year. Ask your employer for these amounts. Your maximum contribution may be less if you are not eligible for the entire tax year. Since your maximum annual contribution includes both your and your employer's contributions, you'll want to first find out what your employer is contributing before you make your employee HSA contribution election.

If you are age 55 or older, you can contribute an additional $1,000. If you have an eligible spouse who is 55 or older and wishes to make a catch-up contribution, your spouse will need to contribute to his or her own HSA.
Please use only whole-dollar amounts.

_____ X _____ = _____
amount per pay period number of pay periods total contribution for the year

2. Premium* expense

On the appropriate enrollment forms I have enrolled in health, dental, and/or vision coverage(s). By my signature on this form, I authorize pretax salary reductions from my wages for my portion of all these premiums where applicable.

These are distinctive from any out-of-pocket expenses you have for medical care and **should not be added in with your medical expense reimbursement account.*

3. Dependent care reimbursement account

This is where you authorize pretax salary reductions for work-related dependent care. Please use only whole-dollar amounts. **You will want to be careful not to overestimate your expenses because money left in the account at the end of the plan year will be forfeited.**

Calendar-year maximum: $2,500 for couples filing separately; $5,000 for a single adult filing as the head of a household or a couple filing jointly. You will need to file Form 2441 with your IRS return, which requires the name, address, and Social Security number or tax ID number of each dependent care provider.

_____ X _____ = _____
amount per pay period number of pay periods total contribution for the year

Please check your elections and calculations carefully, remembering to keep each one separate.

I understand and agree that:

- I cannot change or revoke my dependent care reimbursement election until the next plan year unless I experience a qualifying event for a change (i.e., marriage, divorce, birth, death, adoption, change in employment status, etc.). Specific guidelines apply as outlined in the summary plan description for the Section 125 Cafeteria Plan.
- Any funds remaining in my dependent care reimbursement account at the end of the plan year will be forfeited by IRS regulations to Mennonite Church USA.
- If my employment terminates for any reason, I am bound by the terms of the summary plan description for the Section 125 Cafeteria Plan.
- Any receipt I submit to my dependent care reimbursement account must be for an eligible expense incurred during the applicable plan year.
- I may not claim an income tax deduction or credit for any dependent care expense that is reimbursed from my dependent care reimbursement account.

Employee's signature Date

Part B – To be completed by employee if declining to participate

I do not pay any portion of my health, dental, or vision premiums. I have been given the opportunity to participate in the HSA contributions and dependent care reimbursement options. However, I decline to participate at this time.

Employee's signature Date

If you are electing to participate in the dependent care reimbursement account, return this election form to:
Everence Association, Inc.
attn: TPA Services
P.O. Box 483
Goshen, IN 46527-0483

Dependent care reimbursement benefits are administered by:

The Harrison Group, Inc.
3 Raymond Drive, Suite 201
Havertown, PA 19083
Phone: (610) 853-9075 Fax: (610) 853-9079
Email: service@theharrisongrouponline.com