Election Form

Section 125 Cafeteria Plan for Mennonite Church USA

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

Plan year: Jan. 1 to Dec. 31

If you have any questions about how to complete this form, please contact Deana Roth at Everence, (574) 537-6642.

Congregation or Office _____

Employee name _____
First middle last

Address _____
Street City State ZIP code

Birth date _____ Social Security number _____

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. 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.*

2. Medical expense reimbursement account

This is where you authorize pretax salary reduction for medical expenses you and your family would have throughout the year. 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 year will be forfeited.**

Calendar year maximum: $3,300

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

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: $3,750 for couples filing separately; $7,500 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

over

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

For all of the options listed above, I understand and agree that:

- I cannot change or revoke my elections 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 reimbursement accounts 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 reimbursement account(s) must be for an eligible expense incurred during the applicable plan year.
- I may not claim an income tax deduction or credit for any expense that is reimbursed from either of my reimbursement accounts.
- I certify that any expense I submit to my medical expense reimbursement account has not been reimbursed and I will not seek reimbursement under any other plan covering health benefits.

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 medical expense and dependent care reimbursement account options. However, I decline to participate at this time.

Employee's signature Date

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

Medical expense and 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