SECTION 125 CHURCH FLEXIBLE BENEFIT PLAN ENROLLMENT FORM

SOCIAL SECURITY NUMBER	EMPLOYEE LAST NAME	FIRST NAME	INITIAL

STREET ADDRESS	CITY	STATE	ZIP CODE

GENDER	MARITAL STATUS
☐ MALE ☐ FEMALE	☐ MARRIED ☐ SINGLE
HOME PHONE NUMBER	WORK PHONE NUMBER
( )	( )

EMPLOYMENT INFORMATION

EMPLOYER NAME		UNIT NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

I hereby enroll as a participant in the Flexible Benefit Plan for the plan year beginning January 1, 2013 to December 31, 2013 and I authorize my employer to reduce my Monthly Compensation by the amount specified below in order to purchase benefits under the Plan.

☐ **MCC MEDICAL EXPENSE REIMBURSEMENT ACCOUNT**
I elect to participate in the Medical Care Expense Account to pay for eligible medical care services that are not covered by my insurance coverage.

My employer will withhold each month: $ _____
(Maximum annual contribution is $2,500)
Please Note: Over-The-Counter drugs are no longer reimbursable

☐ **MCC DEPENDENT CARE ASSISTANCE ACCOUNT**
I elect to participate in the Dependent Care Expense Account to pay the eligible expenses for my dependents.

My employer will withhold each month: $ _____
(Maximum annual contribution is lesser of: $5,000/$2,500 if married filing separately/Earned income. See Plan for details)

☐ **EMPLOYER'S PREMIUM SHARING ACCOUNT**
I elect to participate in the Premium Sharing Account in order to pay my employer required monthly medical and/or dental premiums with pre-tax dollars. My employer will deduct the required dollar amount from my paycheck. *Note: Contact your employer regarding your Premium Sharing dollar amount.*

My employer will withhold each month: $ _____

Total Medical Care and/or Dependent Care and/or Premium Share Monthly Contributions $ _____

I understand that the Medical Care Expense Account and Dependent Care Expense Account contributions will be made in **TWELVE EQUAL EVEN DOLLAR AMOUNTS (i.e. $49.99 should be stated as $50.00).** ***By signing below confirms I have read and agree with the terms stated on the reverse side of this form.***

EMPLOYEE SIGNATURE	DATE
EMPLOYER SIGNATURE	DATE

EMPLOYEE: Retain Pink Copy **EMPLOYER:** Retain Yellow Copy
SEND WHITE COPY TO THE MICHIGAN CATHOLIC CONFERENCE
FAX: 517-372-2911 • PHONE: 1-800-395-5565 • www.micatholicconference.org

_____ ("Employer") and I agree that my cash compensation will be reduced by an amount each pay period during the Plan Year to cover the cost of the coverages I have elected above. I agree that if the cost of any of the coverages I have elected for the Plan Year increases or decreases during the Plan Year, the amount of my compensation will be reduced or increased by a proportionate amount.

I understand that:

(a) The amount of my compensation reduction for each pay period during the Plan Year will be credited to an account on the books of the Employer in order to pay for the additional benefits I have elected to receive.

(b) I cannot change or revoke this compensation reduction Agreement at any time during the Plan Year unless I have a "change in status" as defined by the Plan and as allowed by the underlying Group Health Plan (which may include marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Plan Administrator determines will permit a change or revocation).

(c) This Agreement will automatically terminate if the Plan is terminated or discontinued, or if I cease to receive compensation from the Employer which, before reduction under the Plan, is at least equal to the amount of that reduction.

(d) If I am a Highly Compensated Employee or a Key Employee, as defined in the Flexible Benefit Plan, the Plan Administrator may reduce or cancel my compensation reduction or otherwise modify this Agreement to the extent necessary to satisfy certain nondiscrimination requirements of the Internal Revenue Code.

(e) The reduction in my cash compensation under this Agreement shall be in addition to any reductions under other agreements or benefit plans.

(f) The amount of the reduction in my cash compensation for any Plan Year shall be used only to pay for the benefits I have elected to receive during that Plan Year. I will not be entitled to receive benefits in any other form.

(g) Any unused amounts that remain in my Dependent Care Assistance Account after reimbursing my eligible expenses incurred during my participation in the Account during the Plan Year (and for the remainder of the Plan Year if I terminate participation mid-Plan Year), **will be forfeited.**

(h) Any unused amounts that remain in my Medical Expense Reimbursement Account after reimbursing my eligible expenses incurred during my participation in the Account during that Plan Year, **will be forfeited**. I understand that if I terminate participation in the middle of the Plan Year, unlike the Dependent Care Account, I cannot spend down remaining funds. Only expense incurred prior to my date of termination are eligible for reimbursement.

(i) Prior to December 31 of each year, I will be offered the opportunity again to elect certain benefits for the following Plan Year. If I do not complete and return a new Agreement at that time, then I will be treated as having elected to waive all pre-tax medical and dental coverage, as well as Medical Expense Reimbursement and Dependent Care Assistance benefits under the Plan and my pre-tax coverage for those benefits will cease at the end of the Plan Year (December 31).

This Agreement is subject to the terms of the Flexible Benefit Plan; it shall be governed by and construed in accordance with the laws of the State of Michigan; and it revokes any prior compensation reduction agreement and election of nontaxable benefits.