

Cafeteria Plan Worksheet For Officers/Employees

Use this section if salary is not supplemented by the locality

- A. \$ _____ COMPENSATION BOARD MONTHLY SALARY (“Mo CB Sal”)
 B. - _____ TOTAL PREMIUM(S)/FLEX BENEFIT(S) DEDUCTED BEFORE TAXES
 C. = _____ MONTHLY TAXABLE SALARY(enter this amount in SNIP “Mo Tax Sal” Column)

Use this section ONLY if Salary Is Supplemented By The Locality

- A. \$ _____ MONTHLY SALARY REIMBURSABLE BY THE STATE (“Mo CB Sal”)
 B. / _____ TOTAL MONTHLY SALARY (“Mo CB Sal” plus supplement by locality)
 C. = _____ PERCENT OF STATE REIMBURSEMENT
 D. \$ _____ TOTAL PREMIUM(S)/FLEX BENEFIT(S) PAID BY THE OFFICER/EMPLOYEE
 E X _____ ITEM “C” ABOVE (PERCENT OF STATE REIMBURSEMENT)
 F. = \$ _____ PREMIUM(S)/FLEX BENEFIT(S) ALLOCABLE TO STATE
 G \$ _____ ITEM “A” ABOVE: COMPENSATION BOARD MONTHLY SALARY (“CB Mo Sal”)
 H - _____ ITEM “F” ABOVE: PREMIUM(S)/FLEX BENEFIT(S) ALLOCABLE TO STATE
 I = _____ MONTHLY TAXABLE SALARY(enter this amount in SNIP “Mo Tax Sal” Column)

**** PLEASE DO NOT ENTER THE AMOUNT ABOVE (“I”) IN THE “Mo CB Sal” COLUMN ****

Sel: _97/02		Loc: 888	Off: 320	Name: OFFICER’S NAME	804-786-0787		
Pos	SSN	Last Name		Int	New Name	Class	CB P: 2
Mo CB Sal	Mo Tax Sal	Mo Pay Sal	OASDI	Retire	Gp Ins	Tot Sal	SCBRUM02
00003	8888888888	JOHNSON	BA	_____	AAII	23401.00	
1950.08		1950.08	149.18	81.51		2180.77.	

1950.08 **1496.98** 1950.08 114.52 81.51 2146.11

IF ONE OF YOUR EMPLOYEES PARTICIPATES IN THE CAFETERIA PLAN, YOU MUST ADJUST THE “MO TAX SAL” WHENEVER ANY OF THE FOLLOWING OCCURS:

1. The employee’s deduction increases or decreases (i.e. insurance premium).
2. Employees receive a Compensation Board salary increase.
3. Locality supplements the employees’ salaries and the supplement is increased.

If you do not know what the pre-tax deductions are, please contact the payroll person in your locality.

Cafeteria Plan Worksheet For Treasurers/Commissioners

TREASURERS, DIRECTORS OF FINANCE, & COMMISSIONERS OF THE REVENUE

- A. \$ _____ MONTHLY SALARY REIMBURSABLE BY THE STATE (“Mo Pay Sal”)
 B. / _____ TOTAL MONTHLY SALARY (“Mo CB Sal” plus supplement by locality, if any)
 C. _____ PERCENT OF STATE REIMBURSEMENT

- D. \$ _____ TOTAL PREMIUM(S)/FLEX BENEFIT(S) PAID BY THE OFFICER/EMPLOYEE
 X _____ PERCENT OF STATE REIMBURSEMENT (**Item C. Above**)
 E. \$ _____ PREMIUM(S)/FLEX BENEFIT(S) ALLOCABLE TO STATE (Amount to be subtracted from “Mo Pay Sal”)

\$ _____ MONTHLY SALARY REIMBURSABLE BY THE STATE (**Item A. Above**)
 - _____ PREMIUM(S)/FLEX BENEFIT(S) ALLOCABLE TO STATE (**Item E. Above**)
 _____ MONTHLY TAXABLE SALARY (“**Mo Tax Sal**”)

***** PLEASE DO NOT ENTER THE AMOUNT ABOVE IN THE “Mo CB Sal” COLUMN *****

Sel: _ 97/02 Loc: 888 Off: 734 Name: OFFICER’S NAME 804-786-0777
 Pos SSN Last Name Int New Name Class CB P: 2
 Mo CB Sal **Mo Tax Sal** Mo Pay Sal OASDI Retire Gp Ins Tot Sal SCBRUM02
 00003 8888888888 JOHNSON B _____ DI 45579.00
 3798.25 3133.50 239.71 130.98 3504.19
 _ 3798.25 _ **2801.33** 3133.50 214.30 130.98 3478.78

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