

BOARD OF PENSIONS

PENINSULA-DELAWARE CONFERENCE · THE UNITED METHODIST CHURCH

139 N. STATE STREET
DOVER, DELAWARE 19901
(302)674-2626

NAME: _____ CHARGE: _____
SS# _____

Email Address: _____ (Please Print Clearly)

2010 Health Care and Dependent Care Election Sheet and Salary Reduction Agreement

1. Effective January 1, 2010, if you are enrolled in the PPO Conference plan, please indicate persons covered:
 - Self
 - Self with Child(ren): provide name(s) of children covered

 - Family: provide name of spouse and children covered

2. Are you adding or cancelling a family member on January 1, 2010? **No** **Yes**
(if yes, you must download and complete a new BCBS application located under Resources, Forms on www.pen-del.org and return with this form)
3. Are you declining the Conference Coverage? **No** **Yes** (if yes, why? covered under your spouse; covered under your former employer; Other, please explain _____)
4. Is your spouse employed full-time? **No** (if no, skip to question 7) **Yes** (if yes, answer questions 5 and 6)
5. Is your spouse offered health insurance by his/her employer? **No** **Yes**
6. Is your spouse declining his/her employer plan in order to be covered under the Conference health plan? **No** **Yes**
(if yes, you will be billed an additional **\$300 a month** for your spouse's coverage on the Conference health plan)
7. Select one of the following:
 - Select HRA (Health Reimbursement Account) if
 - you are working and you are age 65 or over or you will turn 65 in 2010
 - you are working and your spouse is age 65 or over
 - you are retired but you will turn 65 in the election year
 - you have a secondary insurance that is not a high deductible health plan
 - you prefer this plan (anyone may enroll in HRA)
 - Select HSA (Health Savings Account) if
 - You prefer this plan; are not age 65; will not be 65 this election year; and have no other health insurance (if insuring your spouse, he/she cannot be 65 or have other insurance)

FOR HSA ENROLLEES ONLY:

Do you want to contribute to your **HSA** on a pre-tax basis? **No** **Yes** (if yes, please indicate your monthly contribution: \$ _____ HSA monthly contribution

Name: _____

FOR HRA ENROLLEES OR PERSONS WHO DECLINED CONFERENCE HEALTH INSURANCE:

Do you want to contribute to a **Payflex Health Care Spending Account** on a pre-tax basis? No Yes
(if yes, please indicate your **monthly** contribution: \$_____ **Payflex** monthly Health Care Spending contribution)

Do you want to contribute to a **Payflex Dependent Care** (for children's care who are age 13 or under and both parents work) **Spending Account*** on a pre-tax basis? No Yes
(if yes, please indicate your **monthly** contribution: \$_____ **Payflex** monthly Dependent Care contribution)

Administrative fee for **Payflex** is \$5.80 per month.

Monthly **Payflex** amounts, if applicable, will be deducted from my salary on a pre-tax basis. I understand (1) that by participating in the Health Care Spending Account and/or the Dependent Care Spending Account with PayFlex, I am assuming a risk of forfeiture as described in the Summary Plan Description, and (2) that I may change my benefit election only in limited circumstances as described in the Summary Plan Description.

Employee Signature if participating in Payflex

Date

FOR CLERGY ONLY:

8. Do you serve a full-time pastoral appointment? No Yes (if yes, your monthly contribution is based on your **2009** compensation as reported to the General Board of Pension & Health Benefits, *which includes parsonage factor or housing allowance*)

Indicate monthly contribution: \$_____ (see chart below to determine contribution)
Check box if you are a student local pastor

Compensation*	Monthly Single Coverage	Monthly Family Coverage
\$20000-29999	\$ 32	\$ 53
\$30000-39999	42	75
\$40000-49999	59	101
\$50000-59999	75	128
\$60000 plus	90	154
Retirees/Spouses under 65	42	75
Retirees/Spouses on Medicfill – no contribution required if 20 years or more of service		

ALL PERSONS-PLEASE READ AND SIGN AT THE BOTTOM:

MetLife Dental Plan: Open enrollment for enrolling or adding dependents to the Conference dental plan is January 1, 2010. (Notify the Business Office in writing of enrollment or any changes by November 1, 2009.)

This Health Care and Dependent Care Election Sheet and Salary Reduction Agreement form must be completed and **returned to the Conference Resource Center, Business Office, 139 N. State Street, Dover, DE 19901 no later than November 1, 2009.** A copy of the form will be sent to your Treasurer along with the new 2010 health/dental coupons mailed out in mid December.

Salary Reduction Agreement

I hereby request the Treasurer to reduce my salary, on a pre-tax basis, by any Health Savings Account (HSA) contributions, Payflex contributions and administrative fees, Pastor's contributions, and spousal costs*, as applicable.

Date

Required Signature