Peninsula-Delaware Conference
2023 Health Care and Dependent Care Election Form
and Salary Reduction Agreement

NAME: _____ CHARGE: _____

Email Address: _____ (Please Print Clearly)

1. Effective January 1, 2023, 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 the name(s) of spouse and children covered

   _____

   (Please notify the Business Office within 30 days if changes are made during the year. Failure to do so could lead to denial of coverage or additional cost to the participant)

2. Are you adding or canceling a family member on January 1, 2023? ☐ **No** ☐ **Yes**
   (**if yes**, ***you must download and complete a new Highmark BCBS application located under "Forms" at www.pen-del.org and return the completed Highmark BCBS Application along with this form by November 1, 2022***)

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)** ☐ **No Spouse**

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 or is your spouse using the Conference plan as a secondary coverage? ☐ **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: ☐ ***Mark this box if this will be a change from your current plan***

   ☐ Select HRA (Health Reimbursement Account) if:
   - you are working and you are age 65 or over or you will turn 65 in 2023; or
   - you are working and your spouse is age 65 or over; or
   - you have a secondary insurance that is not a high deductible health plan; or
   - 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 in 2023; and have no other health insurance (if insuring your spouse, he/she cannot be 65 or turn 65 in 2023 or have other insurance)

7a. **FOR HSA ENROLLEES ONLY:**

Do you want to contribute to your **HSA**? ☐ **No** ☐ **Yes** (if yes**,** please indicate your **monthly** Contribution: $_____ HSA pre-tax monthly contribution (maximum $287.00 Indv - $479.00 Family))

Note: For HSA Enrollees**: On January 3, 2023, a contribution to HSA of either $200 (self coverage) or $1000 (family coverage) will be made to your account. A second contribution of $200 (self coverage) or $1000 (family coverage) will be made on July 1, 2023.**

7b. **FOR HRA ENROLLEES AND/OR FSA ENROLLEES:**

Note: For HRA Enrollees: **On January 3, 2023, a contribution to HRA of either $400 (self-coverage) or $2000 (family coverage) will be made to your account.**

Do you want to contribute to a **Highmark Health Care Spending Account**? ☐ **No** ☐ **Yes** (if yes**,** please indicate your **monthly** pre-tax contribution: **$**_____ **Highmark FSA** monthly Health Care Spending contribution
(IRS Ruling: Your monthly Highmark FSA amount cannot exceed $254.16)

Do you want to contribute to a **Highmark Dependent Care Spending Account** (for children's care who are age 13 or under and both parents work)? ☐ **No** ☐ **Yes** (if yes**,** please indicate your **monthly** pre-tax contribution:
$_____ **Highmark** monthly Dependent Care contribution
(Your monthly Highmark amount cannot exceed $416.66)

Administrative fee for **Highmark FSA** is $5.25 per month.

Monthly **Highmark FSA** 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 Highmark, 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 Highmark FSA Date

8a. Full-time pastoral appointment? ☐ **No** ☐ **Yes** (if yes, your monthly contribution is based on your ***2022*** compensation as reported to Wespath Benefits, ***which includes 25% parsonage factor or housing allowance***)

8b. Retired Clergy and/or Spouses under 65? Please indicate your contribution below:
8c. Conference staff? Please indicate your contribution below:

For 8a, 8b and 8c: Indicate monthly contribution: $_____ (see chart below to determine contribution)

Compensation**	**Monthly Single Coverage**	**Monthly Family Coverage**
$20000-29999	$ 50	$ 80
$30000-39999	63	113
$40000-49999	88	153
$50000-59999	113	192
$60000 plus	136	234
Retirees/Spouses under 65	64	113

If you elect Single Medical and Family Dental coverage include an additional contribution of $8.00.

MetLife Dental Plan: Open enrollment for new enrollments or adding dependents to the Conference dental plan is January 1, 2023. **(*You must download and complete a new MetLife application located under "Forms" at www.pen-del.org and return to the Business Office by November 1, 2022.)***

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 prior to November 1, 2022**. ***Please provide a copy of this form to your Treasurer and keep a copy for your records.***
Make sure your email address is correct and legible to ensure you receive your monthly e-billing on time.

Salary Reduction Agreement

I hereby request the Treasurer to reduce my salary, on a pre-tax basis, by any Health Savings Account (HSA) contributions, Highmark FSA contributions and administrative fees, spousal costs*, and Pastor's contributions** as applicable. (Please sign below even if no dollars are reduced from salary. Signature indicates you have read and understand this Election Sheet)

_____ _____
Date- (Required) Required Signature