CHURCH OF THE BRETHREN
INSURANCE SERVICES
A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
1505 Dundee Avenue • Elgin, Illinois 60120-1619
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insurance@cobbt.org • www.bbtinsurance.org

Election Form & Salary Reduction Agreement

Brethren FlexCare

(Employer Groups)

For plan year _____

PART I — IDENTIFYING INFORMATION

Employee Last Name _____ **First Name** _____ **MI** ____

Employee Address _____

City _____ **State** _____ **ZIP** _____ – _____ **Phone** _____

Birth Date _____ **Social Security Number** _____

Email _____

We will use your email address solely to communicate with you about Brethren Insurance Services.

Employer Name _____

PART II — PRE-TAX PREMIUMS

Please refer to the enclosed Brethren FlexCare Election Form Instructions. Remember to include only your portion of the premiums that will be withheld by your employer on a pre-tax basis. If entering the plan mid-year, please prorate the amount to the number of months remaining in the calendar year.

A. Medical Plan
Enter the **employee's** annualized premium for this plan. A. _____

B. Dental Plan ❑ **Option 1** ❑ **Option 2** ❑ **Option 3**
Enter the **employee's** annualized premium for this plan. B. _____
❑ Employee only ❑ Employee + One ❑ Family ❑ No Coverage Elected

C. Vision Plan ❑ **Option 1** ❑ **Option 2** ❑ **Option 3**
Enter the **employee's** annualized premium for this plan. C. _____
❑ Employee only ❑ Employee + One ❑ Family ❑ No Coverage Elected

D. Accident ❑ **Option 1** ❑ **Option 2** ❑ **Option 3**
If you wish to elect this coverage, enter the **employee's** annualized premium for this plan. D. _____
❑ Employee Only ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family ❑ No Coverage Elected

PART III — HEALTH SAVINGS, MEDICAL REIMBURSEMENT, AND DEPENDENT CARE ACCOUNTS

E. Health Savings Account
Enter the amount you wish to elect for the plan year. E. _____

Note: You must be enrolled in the high-deductible health plan to elect this benefit. You may not elect this benefit if you are also enrolled in a traditional-deductible health plan as secondary coverage.

F. Medical Reimbursement Account
Enter the amount you wish to elect for the plan year. This amount must be divisible by 12. F. _____

G. Dependent Care Account
Enter the amount you wish to elect for the plan year. This amount must be divisible by 12. G. _____

PART IV — AFTER TAX PREMIUMS

H. Long-Term Disability
Enter the **employee's** annualized premium for this plan. H. _____

I. Basic Life and Accidental Death and Dismemberment
Enter the **employee's** annualized premium of this plan. I. _____

J. Supplemental Life and Accidental Death and Dismemberment/ Dependent Life and Accidental Death and Dismemberment
Enter the **employee's** annualized premium of this plan. J. _____

K. Short-Term Disability
Enter the employee's annualized premium for this plan. K. _____

PART V — TOTAL

L. Total dollars you have elected to spend (add lines A-K) L. _____

PART VI — SIGNATURES

I hereby authorize my employer to reduce my compensation by the amount indicated on line M above.

I understand that the elections I have made above are irrevocable for the plan year unless I have a qualified change in status, except for the HSA contributions. Changes other than HSA contributions can be made only within 31 days of the date of a qualified change in status. I further understand that any money remaining in my Medical Reimbursement Account or Dependent Care Account after March 15 following the end of the plan year will be forfeited. Any balance in an HSA is not forfeited.

_____ _____
Signature of Employee *Date*

_____ _____
Signature of Employer *Date*

_____
Title of Employer

Note: Brethren Benefit Trust assumes no responsibility for submitting any federal or state income tax documents on your behalf. That responsibility rests with you and your employer. Please keep a copy of this Salary Reduction Agreement for your records.