Cafeteria Plan for Church Use

Election of Medical/Dependent Care Reimbursements and Compensation Reduction Agreement

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Employee Information

Employee Name _____ SSN _____

Employee Address _____

Plan Amount

I elect to receive medical/dependent care reimbursements for the following calendar year :

_____

The amount of compensation reduction will be in the following amount per pay period:

_____

Not less than the following amount per year: Not to exceed the following amount per year*:

_____ _____

**Maximum amount allowed may not be greater than $2500 per year.*

Church Name

_____

The above named church and I hereby agree that my cash compensation will be reduced by the amount set forth above for each pay period during the above calendar year (or during such portion of the year as remains after the date of this agreement).

Additional Plan Options

Please choose one of the following options:

◯ Grace Period Option**

◯ Carryover Option***

◯ None

If you selected the Carryover Option, please indicate the maximum amount allowed for this plan (not to exceed $500):

_____

**Under the grace period rule, a § 125 cafeteria plan may permit an employee to use amounts remaining from the previous year (including amounts remaining in a health FSA) to pay expenses incurred for certain qualified benefits during the period of up to two months and 15 days immediately following the end of the plan year. (IRS Notice 2013 -71)

***The carryover option permits an employer to provide for the carryover to the immediately following plan year of up to $500 of any amount remaining unused as of the end of the plan year in a health FSA. The same carryover limit must apply to all participants. (IRS Notice 2013-71)

Agreement

I understand the following:

- The amount of my compensation reduction for each pay period during the year will be credited to a medical/dependent care reimbursement account for the year on the books of the church, and I will be reimbursed up to the balance in that account, for my qualifying medical/dependent care expenses incurred during the year.

- Reimbursement will be available only for “qualifying medical/dependent care expenses.” I agree to notify the church if I have reason to believe that any medical/dependent care expenses for which I have obtained reimbursement is not a qualifying expense. I also agree on demand to indemnify and reimburse the church for any liability it may incur for failure to withhold federal and state income tax or Social Security tax from any reimbursement I receive of a non-qualifying expense, up to the amount of additional tax actually owed by me.

- I cannot change or revoke this compensation reduction agreement at any time during the calendar year unless I have a change in family status, (including 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).

- This agreement will automatically terminate if the plan is terminated or discontinued, or if I cease to receive compensation from the church which, before reduction hereunder, is at least equal to the amount of that reduction.

- The plan administrator may reduce or cancel my compensation reduction or otherwise modify this agreement in the event he believes it advisable in order to satisfy certain provisions of the Internal Revenue Code.

- The reduction in my cash compensation under this agreement shall be in addition to any reductions under other agreements or benefit plans.

This agreement is subject to the terms of the above named church Cafeteria Plan and Medical/Dependent Care Reimbursement Plan as from time to time in effect, shall be governed by and construed in accordance with the laws of Ohio, shall take effect as a sealed instrument under the laws of Ohio, and revokes any prior election and compensation reduction agreement relating to the Medical/Dependent Care Reimbursement Plan.

Pastor's Signature: Date:

Advisory Committee Member's Signature (if applicable): Date:

Advisory Committee Member's Signature (if applicable): Date:

Advisory Committee Member's Signature (if applicable): Date:

Church Multiplication Director's Signature: Date:

Network Secretary's Signature: Date: