SUSQUEHANNA CONFERENCE OF THE UNITED METHODIST CHURCH

HEALTH INSURANCE PREMIUM SALARY REDUCTION AGREEMENT

Participant Name:_____S.S. # _____

Salary-Paying Unit/Employer: _____

PURPOSE OF THIS AGREEMENT:

This agreement is to set forth the terms of making before-tax (salary reduction) contributions to the payment of health premiums owed by the participant named above to the Susquehanna Conference of the United Methodist Church for the conference's self-insured health coverage. This plan is administered by the Susquehanna Conference of the United Methodist Church and Health Flex.

Such contributions DO NOT APPEAR IN Box 1 of the W-2 to the participant.

TERMS OF THE AGREEMENT

The term of this agreement are for one year or shall end on the date the agreement is terminated or changed, the termination of the participant's employment with the salary-paying unit/employer, or the participant's death.

AGREEMENT

Beginning date of this agreement (specify month, day and year): _____

(NOTE: This must be a date subsequent to the date on which this agreement is signed. This agreement will be in effect until a new agreement is In place.)

The participant's annual eligible compensation (Base Salary + SS Offset) on the beginning date of this agreement shall be reduced (deducted from paycheck) by the difference between the premium credit provided and the actual cost of medical and/or dental and vision plans selected during annual election. Additionally, if a medical reimbursement account (FSA) or a Dependent Care Account (DCA) is selected during annual election, please note that they are handled the same as the health insurance for payroll tax purposes.

The premium credits for 2019 are as follows:

Single - $7,500 per year
Participant +1 - $14,300 per year
Family - $18,100 per year

Actual Cost of Premiums(from Annual Election) $_____
Amount to be deducted annually by the salary paying unit (difference between the Premium Credit and Actual Cost $_____

FSA annual amount selected $_____ DCA annual amount selected $_____

HSA selected (only if choosing a HDHP)_____

This reduction in compensation will occur:_____twice a month;_____bi-weekly;_____monthly

ACCEPTANCE BY THE SALARY-PAYING UNIT/EMPLOYER and the PARTICIPANT:

Salary-Paying Unit/Employer Authorized Signature:_____Date: _____

Participant Signature:_____Date: _____