Diocese of Central Florida, Incorporated Cafeteria Plan
2024 Election/Waiver Form & Salary Reduction Agreement

Diocesan Location: City: _____ Church:_____

Employee Name: _____ Email: _____

Home Mailing Address: _____

City, State, Zip _____

Birthdate: _____ Social Security Number: _____ Date of Hire: _____

I have reviewed the terms of the Diocese of Central Florida, Incorporated Cafeteria Plan (with Premium Payment and HSA Components) ("the Plan"). (Capitalized terms used in this Election Form/Salary Reduction Agreement ("the Agreement") have the meanings set forth in the Plan document.) I understand that I may elect coverage for the **2024** calendar year under any or all of the following two Plan Components:

- Premium Payment Component, under which I can pay for my share of my employer sponsored, through the Episcopal Church Medical Trust, Medical and Dental Insurance premiums with pre-tax dollars; and
- HSA Component, under which I can make pre-tax contributions to my HSA paired with a Consumer Directed Health Plan (CDHP) through the Episcopal Church Medical Trust established and maintained by me outside the Plan with my HSA trustee/custodian.

Election of Pre-Tax Benefits Under the Salary Reduction Plan

I elect to receive the following coverages under the Plan. I understand that an amount equal to the annual contributions for the coverages I have elected, divided by the number of pay periods in the Plan Year, will be deducted on a pre-tax basis from each of my paychecks (unless another method is prescribed by the Plan Administrator) to pay for the coverages that I elect.

☐ **Pre-Tax Premium Payment Benefits**: On separate benefit enrollment form(s), I have enrolled for these insurance coverages and I have received a schedule showing my share of the premiums for such coverages.

Dollar $ amount of my share of the ANNUAL Premium to be withheld Pre Tax	Coverage
$_____	Major Medical Health Insurance Premium
$_____	Dental Insurance Premium

☐ **HSA Benefits**: $_____/year (annual maximum is the applicable statutory maximum for my HDHP coverage type (i.e., single or family)). (**Note: $4,150 for single and $8,300 for family are the statutory maximum amounts for 2024—an additional $1,000 may be contributed if you are 55 or older)**.

Certification: By electing HSA Benefits, I am certifying that I meet the requirements under Internal Revenue Code § 223 to be eligible to contribute to an HSA. (For more information about HSA eligibility requirements, see IRS Publication 969.)

Requirement to Provide HSA Information: Participants electing HSA Benefits must provide sufficient identifying information about the Participant's HSA to facilitate the forwarding of contributions through the Employer's payroll system to the Participant's designated HSA trustee/custodian.

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Waiver of Pre-Tax Benefits Under the Salary Reduction Plan; Election of After-Tax Benefits

☐ I elect to waive all pre-tax benefits under the Plan. I understand that if I have enrolled for Medical Insurance coverage on a separate benefit enrollment form, I will pay my share of the contribution with after-tax payroll deductions. Except for a Change in Election Event for the applicable Benefit (as described below), I understand that I cannot elect pre-tax benefits until the next Open Enrollment Period, and any after-tax coverages shall be outside the Plan.

Elections Irrevocable Unless Exception Applies
I understand that I cannot change or revoke this Agreement as of any date prior to the next January 1, unless a Change in Election Event occurs as defined in the Plan (e.g., termination of employment, divorce, marriage, etc.), and the election change is on account of and is consistent with the Change in Election Event, as described in the Plan. My HSA contribution election can be changed prospectively, for any reason.

Additional Terms
I agree that my Compensation will be reduced by the amount of my required contribution for the Benefits that I have elected under the Plan and that such Salary Reductions will continue for each pay period until this Agreement is amended or terminated. I understand that my contribution for the Medical Insurance Benefits may be automatically increased or decreased for changes by the Plan Administrator. I also understand the following:

- Signing this Agreement does not initiate my coverage under the Medical Insurance policy. I must complete a separate Medical Insurance enrollment form to start my Medical Insurance coverage.
- Salary Reductions under this Agreement reduce my Compensation for Social Security tax purposes. This means that my Social Security benefits could be decreased because of the decreased amount of compensation that is considered for Social Security purposes.
- Prior to December 31 of each year, I will be offered the opportunity again to elect Premium Payment and HSA coverage for the following Plan Year. If I do not complete and return a new Agreement at that time, then I will be treated as having elected to waive all pre-tax benefits under the Salary Reduction Plan and my pre-tax coverage will cease at the end of the Plan Year (December 31).

I have read and agree to the terms of participation and to any applicable certifications set forth in this Agreement. Any previous election and agreement under the Plan relating to the same Benefits, including any prior Election Form/Salary Reduction Agreement, is hereby revoked.

_____
Employee's Signature Date

Accepted and agreed to:

_____
Plan Administrator's Signature (Church Treasurer/Parish Administrator) Date

Send copies of the final signed forms (scan/email or USPS mail) to:

Email: bjennings@cfdiocese.org

Diocesan of Central FL
Attn: Beverly Jennings
1017 East Robinson St.
Orlando, FL 32801-2023