



2010 Clergy Salary Redirection Agreement for IGRC-Sponsored Plans

Calendar Year Plan – All Benefits

You Cannot Add or Drop Coverage During the Year Unless You Experience a Qualifying Life Event Change During the Plan Year

SECTION A: PARTICIPANT DATA – PLEASE PRINT IN BLUE OR BLACK INK

<u>EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)</u>	<u>SOCIAL SECURITY NUMBER</u>	<u>ENROLLMENT DEADLINE IS DECEMBER 1, 2009</u> Return completed form to: The Illinois Great Rivers Conference ATTN: Teri Casson, PO Box 19207, Springfield, IL 62794-9207 or fax to 217-529-4107 PLEASE RETAIN A COPY FOR YOUR RECORDS
<u>HOME ADDRESS</u>	<u>DATE OF BIRTH</u>	
<u>CHURCH/CHARGE NAME & ADDRESS:</u>	<u>MARITAL STATUS</u> <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	
Name of District: _____	<u>GENDER</u> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

SECTION B: YOUR BEFORE-TAX BENEFIT ELECTIONS

Indicate your Salary Reduction Selections by checking those which apply.

1. **HEALTH INSURANCE CONTRIBUTION:** IF YOU ARE CHANGING SPOUSE COVERAGE, you must contact Robin Coats Gauss at rcoatsgauss@igrc.org or 217-529-2308. Accepting the Health Insurance Contribution **does not constitute enrollment** in the Conference Group Insurance plan.

Accept

Decline

\$60 per month for Group Health Insurance for Pastor and Children (Mandatory for full-time Pastors)

\$300 per month for Group Health Insurance for Spouse of the Pastor

If coverage for the Spouse is declined, please list where the Spouse has insurance coverage: _____

2. **HEALTH CARE FLEXIBLE SPENDING ACCOUNT:** \$ _____ Total per year (\$6,000 maximum) - for reimbursement of medical expenses not covered by insurance.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT: \$ _____ Total per year (\$5,000 maximum) - for child or dependent adult day care expenses

By signing below, you are confirming that your dependents meet the plan's dependent eligibility requirements and you are agreeing to notify the Conference Benefits Office within 30 days of an event that causes any of these dependents to no longer meet the definition of an eligible dependent under the plans in which they are covered. If these dependents do not meet the plan's dependent eligibility requirements or if you fail to notify us within 30 days of an event that causes any of your dependents to lose dependent status (e.g. divorce, child reaching limiting age etc.), you may experience serious consequences in your coverage – including **additional charges which you must pay**.

I hereby authorize my Local Church (or employer) to reduce my salary as indicated above. I understand that this election will remain in effect until the last day of the plan year "December 31". I further understand that I may not make a change to this request unless there is a Qualifying Life Event Change and that I must notify the Conference Benefits Office within 30 days of a Qualifying Life Event Change. Monies cannot be transferred within a health care flexible spending account. Money remaining in my Flexible Spending Accounts 90 days after the end of the plan year cannot be refunded.

_____ Signature	_____/_____/_____ Date	_____ Daytime Phone Number
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