



**SECTION 125
HEALTH CARE BENEFITS PAYROLL DEDUCTIONS**

Plan Year: July 1st, 2018 through June 30th, 2019

Enrollment in the Section 125 Plan of the Diocese of Santa Rosa allows eligible active employees to reduce their taxable income by withholding qualifying benefit premiums BEFORE taxes. When you begin employment in an eligible position you have the right to be enrolled in the Health Care Coverage offered by the Diocese of Santa Rosa effective the 1st of the month following or coinciding with your eligibility date.

EMPLOYEE INFORMATION

Employee name	SS#	Date of Birth
Email address	Telephone #	
Benefits eligible date	Entity/Location Name and City	

AUTHORIZATION

I elect and authorize payroll deduction for Health Care Coverage under the Section 125 Plan of the Diocese of Santa Rosa in the amount of \$ _____ per month / \$ _____ per pay period. Effective date: _____.

DECLINATION

I elect not to participate in the "Health Care Coverage" for myself under the Section 125 Plan of the Diocese of Santa Rosa at this time. I am covered under my spouse's or my parents' health coverage. I understand that I will not receive any compensation for declining this benefit.

I elect not to participate in the "Dependent Health Care Coverage" under the Section 125 Plan of the Diocese of Santa Rosa at this time.

CONSENT

I UNDERSTAND THAT by signing and submitting this form I am making a binding election effective July 1st, 2018, and I cannot make any changes to my coverage until the beginning of the next plan year, July 1st 2019, "unless" I experience a qualifying life event (QLE). Prior to the first day of each plan year I will be offered the opportunity to change my benefit election for the following plan year. If I do not complete and return a new election form at that time, I will be treated as having elected to continue the same benefit coverage and rates in effect for the new plan year.

I UNDERSTAND THAT whether **electing** or **waiving my right to elect** the health package offered to me as of my eligibility date, I must complete the online enrollment process at www.RetaTrust.org within 30 days of my eligibility date noted above.

Participant Signature

Date

For Location use only:
 Date form Rec'd: _____ Info added to RetaTrust.org: _____ Deductions entered in IBS: _____
 "If employee is waiving benefits, please provide a copy to the Benefits Department"