

Enrollment Form
The Diocese of Bridgeport Medical Reimbursement Plan

Effective Date: _____

Place of Work: _____

Employee Information

Name: _____
 (Last, First, Middle Initial)

Social Security #: _____ - _____ - _____

Home Address: _____
 (Street Address)

Date of Hire: ____/____/____

 (City, State ZIP Code)

Marital Status (check one): [] Single [] Married

Dependents to be Covered

<u>Last Name, First Name</u>	<u>Sex</u>	<u>Birth Date</u>	<u>Social Security Number</u>	<u>Relationship to Employee</u>
_____	_____	___/___/___	____ - ____ - ____	_____
_____	_____	___/___/___	____ - ____ - ____	_____
_____	_____	___/___/___	____ - ____ - ____	_____
_____	_____	___/___/___	____ - ____ - ____	_____
_____	_____	___/___/___	____ - ____ - ____	_____

Annual Reduction-Plan Year (From 01/01/2011 to 12/31/2011)

You are reducing your annual compensation to pay for eligible health costs that may not be covered by our benefit plan(s). In essence, you will be paying for these expenses on a pre-tax basis. This is a voluntary plan and the amount you designate as your Annual Salary Reduction should be conservative. Remember, if you do not utilize the funds, you lose them. The maximum Annual Salary Reduction is **\$4,000.00**.

<u>Entry Date Into the Plan (First Payroll Reduction)</u>	<u>Number of Remaining Pay Periods</u>	<u>Desired Reduction Per Pay Period</u>	<u>Annual Reduction Amount (Pay Periods X Desired Reduction)</u>
___/___/___	_____	\$ _____	\$ _____

Salary Reduction Agreement

I have read and understand the Explanation of Benefits detailing the The Diocese of Bridgeport Medical Reimbursement Plan. With this authorization, I am directing The Diocese of Bridgeport to reduce my annual compensation by the Total Annual Reduction amount shown and reimburse me upon submitting eligible receipts. By reducing my annual compensation, I am essentially paying for uncovered benefits with pre-tax dollars. I understand that this annual reduction is irrevocable and cannot be changed unless a "Change in Life Status" is experienced.

 (Signature)

 (Date)