The Diocese of Santa Rosa

SECTION 125 ELECTION FORM
HEALTH CARE BENEFITS PAYROLL DEDUCTIONS

Plan Year: July 1st, 2020 through June 30th, 2021

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

_____ XXX-XX- _____ SSN

_____ Date of birth

_____ Email address

_____ Telephone #

_____ Benefits eligible date

_____ Entity 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 because ***I am covered*** *under my spouse's or my parent's or other health coverage*. I must provide proof of this coverage and because I am benefit eligible, I understand I may not pursue coverage through the California Insurance Exchange at any time.

☐ I elect not to enroll my eligible dependent/s in the "Health Care Coverage" under the Section 125 Plan of the Diocese of Santa Rosa at this time.

CONSENT

By signing below:

- I UNDERSTAND by signing and submitting this form I am making a binding election effective July 1st, 2020, and I cannot make any changes to my coverage until the next open enrollment period "unless" I experience a qualifying life event (QLE).

Newly eligible employees: Whether you are **electing** or **waiving your right to elect** the health package offered to you, please complete the online enrollment process at www.RetaTrust.org within 30 days of the benefits eligible date noted above.

_____ Participant Signature

_____ Date

For entity use only:

Date form Rec'd: _____ Info added to RetaTrust.org: _____ Deductions entered in IBS: _____

*Please note: If employee is waiving benefits, please provide a copy along with proof of coverage to the Diocesan Benefits Office: FAX 707-566-3381