

Name - First, M, Last, Suffix Gender M/F Tax ID/SSN Date of Birth

Home Address Clergy or Lay Home Phone Personal Email Address
 City State Zip Active or Retired Cell Phone Work Email Address

Employer Employer Address

Employer Contact Person Employer Contact Position Employer Contact Phone Employer Contact Email

Hire Date Position Title Annual scheduled hrs. Salaried or hourly? O.T. Exempt?

Annual Income Amounts		Housing	
\$ <input type="text"/>	Cash Stipend	<input type="text"/> Y/N	Church/employer provided housing?
\$ <input type="text"/>	Housing Allowance	<input type="text"/> Y/N	Are meals provided?
\$ <input type="text"/>	Social Security Tax Reimbursement	<input type="text"/> Y/N	Housing Equity - amount: <input type="text"/> \$
\$ <input type="text"/>	Employer-Paid Tuition for Dependents	<input type="text"/> Y/N	Utilities - Yearly amount: <input type="text"/> \$
\$ <input type="text"/>	Other Taxable Income	<input type="text"/> Y/N	Cash compensation for housing? <input type="text"/> \$

PENSION PLAN

Employers are required to provide Pension Benefits if the employee works 1000 or more hours or is a salaried clergy.

Pension Plan: Clergy Clergy Defined Benefit Not eligible with CPG
 Lay Defined Benefit (9%) Defined Contribution (5% Base + 4% Matching)

INSURANCES

Employees may participate in insurance benefits at their cost if the employee works 1000 hours or more.
 Employers must offer insurance benefits to the Employee if the employee works 1500 or more hours or is a salaried clergy.
 Effective Date Enrollment/Change (MM/DD/YYYY)

Please mark Yes or No for each insurance plan below.

Medical Insurance Y/N

Plan Number	Plan Name	First Names of Dependents to be included
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage paid by employer: _____ % Employee 100% or _____ % Spouse/Partner _____ % Dependents _____ %		

If no, please provide source of health coverage, level of coverage, and % paid by institution/employer.

Dental Insurance Y/N

Plan Number	Plan Name	First Names of Dependents to be included
<input type="text"/>	<input type="text"/>	<input type="text"/>
Percentage paid by employer: _____ % Employee 100% or _____ % Spouse/Partner _____ % Dependents _____ %		

Group Life/ADD \$50,000 for Clergy (additional to that provided by the pension benefits), \$30,000 for lay employees.
 Y/N Percentage paid by employer: _____ % Employee 100% or _____ % Spouse/Partner _____ % Dependents _____ %

Supplemental Life Insurance above the standard Group Life plan above is available. Contact the Finance Administrator for details.
 Y/N Percentage paid by employer: _____ % Employee 100% or _____ % Spouse/Partner _____ % Dependents _____ %

Short Term Disability Insurance Y/N Percentage paid by employer: _____ % Employee 100% or _____ % Spouse/Partner _____ % Dependents _____ %

Long Term Disability Insurance Y/N Percentage paid by employer: _____ % Employee 100% or _____ % Spouse/Partner _____ % Dependents _____ %

Marital Status: (Single, Married, Divorced, or Widow/Widower)

Spouse's Name: Marital Status Effective Date: Social Security No. Date of Birth Gender M/F

Dependent Information

Med	Den	Name (First, MI, Last, Suffix)	Tax ID/SSN	Date of Birth	Gender	Relationship
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Institution Name and Address:

Employer Signature Date Employee Signature Date
 Employer Printed Name Employee Printed Name
 Employer Position

2017 Insurance Benefit Costs

Medical		2017 Monthly Cost				2017 Yearly Cost			
Code	Plan Name	Single	Emp+1	Emp+ children	Family	Single	Emp+1	Emp+ children	Family
MEAP	EAP	\$5	\$5	\$5	\$5	\$60	\$60	\$60	\$60
MHDE	Anthem BCBS High Deductible Health Plan	\$606	\$1,212	\$1,091	\$1,818	\$7,272	\$14,544	\$13,092	\$21,816
MSPV	Anthem PPO 75/50	\$708	\$1,416	\$1,274	\$2,124	\$8,496	\$16,992	\$15,288	\$25,488
MSPZ	Anthem PPO 80/60	\$827	\$1,654	\$1,489	\$2,481	\$9,924	\$19,848	\$17,868	\$29,772
MSP0	Anthem PPO 90/70	\$889	\$1,778	\$1,600	\$2,667	\$10,668	\$21,336	\$19,200	\$32,004
Medicare Supplemental Plans (Available only if Medicare eligible)									
MSG5	Anthem PPO MS 75/50*	\$608	\$1,216	\$1,094	\$1,824	\$7,296	\$14,592	\$13,128	\$21,888
MSG3	Anthem PPO MS 80/60*	\$661	\$1,322	\$1,190	\$1,983	\$7,932	\$15,864	\$14,280	\$23,796
MSG2	Anthem PPO MS 90/70*	\$727	\$1,457	\$1,309	\$2,181	\$8,724	\$17,488	\$15,708	\$26,172

Dental		2017 Monthly Cost				2017 Yearly Cost			
Code	Plan Name	Single	Emp+1	Emp+ children	Family	Single	Emp+1	Emp+ children	Family
DDPV	Preventive Dental	\$31	\$62	\$56	\$93	\$372	\$744	\$672	\$1,116
DD50	Basic Dent-50/150	\$52	\$104	\$94	\$156	\$624	\$1,248	\$1,128	\$1,872
DD25	Dent&Ortho-25/75	\$68	\$136	\$122	\$204	\$816	\$1,632	\$1,464	\$2,448

Group Life & ADD		Monthly	Coverage Amount	Yearly
Code	Plan Name			
Life/ADD	GLIFE Group Life - Clergy	\$32.50	\$50,000	\$390.00
Life/ADD	GLIFE Group Life - Lay Employee	\$19.50	\$30,000	\$234.00

Short Term Disability <i>(Lay Employee only, Clergy is provided by Pension Plan)</i>							
Code	Plan Name	Salary			Yearly		
		< \$25,000	< \$45,000	>=\$45,000	Monthly	Monthly	Monthly
IRP	GIRPC STD	\$8.00	\$17.50	\$32.00	\$96.00	\$210.00	\$384.00

Long Term Disability	
Code	Plan Name
LTD	GLTDLN LTD EMR PAID
Rate is \$0.58 per \$100 of salary	