

**ARCHDIOCESE OF CINCINNATI
CAFETERIA PLAN**

Benefit Election and Compensation Redirection Agreement

Name: _____

Address: _____

Social Security Number: _____

On a separate benefit enrollment form, I have enrolled for certain medical and/or dental insurance coverage. I hereby elect to receive this insurance coverage under the Archdiocese of Cincinnati Cafeteria Plan.

I and the Archdiocese of Cincinnati agree that my pay will be reduced by the amount of my required contribution for the benefit options I have elected under the Cafeteria Plan, effective July 1, 2010 and continuing for each succeeding pay period until this agreement is amended or terminated. The amount of my required contribution for the medical and/or dental benefit options selected have been separately communicated to me by Archdiocese of Cincinnati.

I understand that I cannot change or revoke my election prior to the next annual Open Enrollment period, unless I experience one of the limited events detailed in the plan document and provided for by the IRS. **If I experience one of these changes and want to make a change to my benefits, I must make the changes and submit to the employer within 31 days after the change occurs.**

I understand that I must complete separate health insurance enrollment form(s) provided by the Archdiocese of Cincinnati.

Under current law salary reduction contributions are not counted when determining FICA earnings. If an employee earns less than the Social Security base wage, his eventual Social Security benefits could be slightly reduced. The value of income and FICA tax savings will normally exceed any eventual reduction in Social Security benefits.

Employee's Signature

Date