

INTRODUCTION

Health Reimbursement Arrangement (HRA) Presbytery of Blackhawk

For Installed Pastors and Associate Pastors (and guidance for other employees with benefits)

This Health Reimbursement Arrangement (HRA) is intended to bring the Presbytery of Blackhawk's requirement of a 6% medical reimbursement for installed pastors and associate pastors into compliance with Federal law. It is based on a template provided by the Board of Pensions (PCUSA).

This document includes:

- The HRA policy
- Sample enrollment form
- Sample reimbursement request form

This HRA policy must be approved by each session that is affected by the 6% reimbursement requirement and cannot be amended except by action of the Presbytery of Blackhawk.

The enrollment and reimbursement request forms can be changed to suit the needs of the local church if consistent with the requirements in the HRA.

Personnel Committee
Presbytery of Blackhawk

Health Reimbursement Arrangement Plan (HRA)

This Health Reimbursement Arrangement plan describes the healthcare expense reimbursement benefits required for installed clergy in the Presbytery of
Blackhawk

Adopted and Affirmed by

The [*church name*] Presbyterian Church

Effective [_Date of Session Action_]

TABLE OF CONTENTS

	Page
ARTICLE I DEFINITIONS	2
Benefits Plan	2
Claim Administrator	2
COBRA	2
Code	2
Dependent	2
Effective Date	2
Eligible Employee	2
Employer	3
Enrollment Form	3
Health Care Expense	3
HIPAA	3
HRA Account	3
Incurred	3
Participant	3
Period of Coverage	3
Plan	4
Plan Administrator	4
Plan Year	4
Primary Medical Plan	4
Qualifying Change in Status	4
Spouse	4
ARTICLE II ELIGIBILITY AND ENROLLMENT	5
2.01 Eligibility	5
2.02 Enrollment	5
ARTICLE III TERMINATION OF BENEFITS	5
3.01 Termination Date of Coverage	5
3.02 Coverage Following Severance	6
3.03 Leaves of Absence	6
ARTICLE IV REIMBURSEMENT BENEFITS	6
4.01 Provision of Benefits	6
4.03 Limitations on Reimbursements and Forfeitures	6
4.04 Annual Limits	7
4.05 Expense Reimbursement Procedure	7
4.06 Coordination with Other Sources, Including Flexible Spending Accounts	7

4.07	Reimbursement After Termination (Run-Out)	8
ARTICLE V PAYMENT OF BENEFITS		8
5.01	Application for Benefits	8
5.02	Assignment of Benefits	8
5.03	Payment to Representative	8
5.04	Responsibility for Payment	9
5.05	Overpayments	9
5.06	Missing Person	9
ARTICLE VI ADMINISTRATION OF THE PLAN		9
6.01	Administration of the Plan*	9
6.02	Appointment of Claim Administrator	9
6.03	Powers of the Plan Administrator	10
6.04	Claims Procedure	10
6.05	Records and Reports	11
6.06	Fiduciary Duty and Care	11
6.07	Limitation on Liability	12
6.08	Indemnification	12
ARTICLE VIII MISCELLANEOUS		12
8.01	Effect on Employment	12
8.04	Governing Law	12
8.05	Family Medical Leave Act	13
8.06	Uniform Services Employment and Reemployment Rights Act	13
8.07	Invalid Provisions	13
REIMBURSEMENT FORM		14
ENROLLMENT FORM		15

INTRODUCTION

This Health Reimbursement Arrangement (the “Plan”) is established by the Presbytery of Blackhawk to be adopted by its member churches to provide pastors and associate pastors of churches in Blackhawk Presbytery with the opportunity to receive reimbursement of certain health care expenses. This document constitutes the Plan, effective [_____]

This Plan is funded solely by the employer and reimburses qualified health care expenses of a pastor or associate pastor and dependents up to 6% of effective salary. The Plan is offered as a supplement to the employer’s primary health insurance coverage. A participant must be enrolled in the primary health plan as a condition of participation in this Plan.

This Plan is sponsored by a church organization and is intended to be a church plan as defined in section 414(e) of the Internal Revenue Code, as amended (“Code”) that has not made an election under section 410(d) of the Code and is therefore exempt from the requirements of the Employment Retirement Income Security Act of 1974 generally applicable to such plans.

This document is meant to comply with Federal law. The Presbytery of Blackhawk may amend this plan as necessary to remain compliant or as its policies regarding pastors and associate pastors may evolve. In the event any discrepancies exist between this document and any amendment, the amendment shall govern.

This Plan is intended to qualify as a “health reimbursement arrangement” within the meaning of IRS Notices 2002-45 and 2013-54, and as an “accident and health plan” within the meaning of section 105(e) of the Code, and any other pertinent laws or regulations, so that the benefits provided under the Plan shall be eligible for exclusion from each Employee’s income for federal income tax purposes under section 105(b) of the Code. The provisions of this Plan shall be interpreted in accordance with that intent.

This HRA can also apply to persons in Temporary Pastoral Positions, Commissioned Ruling Elders, and other employees who are covered by the Board of Pensions Benefits plan.

ARTICLE I

DEFINITIONS

The following capitalized words and phrases, when used in the text of this document and any attachment or materials incorporated herein or amendment hereto, have the meanings set forth below. Wherever any words are used in the singular form, they shall be construed as if they were also used in the plural form in all cases where the plural form would so apply, and vice versa. Where the definitions include rules regarding the definition, those rules shall apply.

Benefits Plan

Benefits Plan means the Benefits Plan of the Presbyterian Church (U.S.A.) administered by the Board of Pensions of the Presbyterian Church (U.S.A.)

Claim Administrator

Claim Administrator means [*fill in the position or title of person or persons who will process reimbursement claims*] or others who from time to time may be appointed by the Employer, who shall process all or a designated portion of the claims under this Plan in accordance with the Plan's terms.

COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. Church plans are exempt from certain COBRA requirements applicable to medical or cafeteria plans. The Benefits Plan provides for medical continuation coverage that is comparable to COBRA coverage.

Code

Code means the Internal Revenue Code of 1986, as amended from time to time.

Dependent

Dependent means an Employee's covered partner and any individual who is a dependent of the Employee within the meaning of section 152 of the Code, as modified by statute, regulation, or otherwise.

Effective Date

Effective Date means [_____]. The Effective Date of any amendment or restatement is the effective date specified in the amendment or restatement.

Eligible Employee

Eligible Employee means a Pastor or Associate Pastor who is an Eligible Employee within the meaning of Section 2.01.

Employer

Employer means [*church name*].

Enrollment Form

Enrollment Form means a form prescribed by the Plan Administrator for purposes of enrolling for coverage under the Plan.

Health Care Expense

Health Care Expense means any co-pay, deductible, or out-of-pocket expense incurred by a Participant, covered Dependent and Spouse that is an expense for medical care within the meaning of section 213(d) of the Code (including dental, vision and hearing), excluding expenses reimbursed by any other health care plan, and other expenses for which coverage under this Plan is proscribed by the Code or other applicable law. The Plan Administrator shall determine whether any other amount constitutes a Health Care Expense that qualifies for reimbursement hereunder.

Excluded from allowable health care expenses are cosmetic surgery and health club dues.

This Plan is intended to provide reimbursements for Health Care Expenses incurred by Eligible Employees.

HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

HRA Account

HRA Account means the HRA Account described in the introduction

Incurred

Incurred means, with respect to Health Care Expenses, provided with health care services or supplies. Health Care Expenses are Incurred as of the date they are provided and not the date they are formally billed or charged or the date they are paid.

Participant

Participant means any pastor or associate pastor for whom coverage is in effect under this Plan.

Period of Coverage

Period of Coverage shall mean the Plan Year, except that:

- (a) for pastors or associate pastors who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 2.01; and
- (b) for pastors and associate pastors who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 2.02.

Plan

Plan means the [*church name*] Health Reimbursement Arrangement, as described herein and as amended from time to time.

Plan Administrator

Plan Administrator means [*fill in the name of the person, persons or committee identified to serve as Plan Administrator in Section 6.01*].

Plan Year

Plan Year means the period beginning [*insert budget or fiscal year beginning*] and ending [*insert end of budget or fiscal year*].

Primary Medical Plan

Primary Medical Plan means the Medical Plan of the Presbyterian Church (U.S.A.).

Qualifying Change in Status

Qualifying Change in Status means, as determined by the Plan Administrator, subject to any restriction under applicable law, the occurrence of one of the following events:

- (a) an event that changes a pastor or associate pastor's legal marital status, including marriage, death of a covered partner, divorce or dissolution of a marriage or qualified covered partnership, legal separation, or annulment;
- (b) an event that changes the number of a pastor or associate pastor's Dependents, including birth of a child, adoption, or placement for adoption or death of a Dependent;
- (c) a termination or commencement of employment, a commencement of or a return from a leave of absence;
- (d) an event that causes the eligibility of an Eligible Employee's Dependent for coverage under this Plan to change, including attainment of a limiting age; or

Spouse

Spouse means "spouse" as defined under federal law.

ARTICLE II

ELIGIBILITY AND ENROLLMENT

2.01 Eligibility

- (a) Installed Pastors and Associate Pastors are enrolled in the HRA upon active employment.
- (b) Pastors and Associate Pastors in temporary pastoral relationship with the church are eligible to participate as of the Effective Date of the Board of Pensions Medical Plan coverage if offered.

2.02 Enrollment

A Pastor or Associate Pastor must be enrolled for coverage in the Board of Pensions, Presbyterian Church (U.S.A.) Medical Plan and submit a completed Enrollment Form to the Plan Administrator. Coverage is effective immediately for the installed Pastor/s and Associate Pastor/s.

ARTICLE III

TERMINATION OF BENEFITS

3.01 Termination Date of Coverage

A Pastor's or Associate Pastor's participation in the Plan shall terminate as of the earliest of:

- (a) the date the individual ceases to be enrolled in the employer's Primary Medical Coverage.
- (b) the date as of which the individual dies, retires or otherwise ceases to be an Eligible Employee; or
- (c) the date as of which the individual enters the armed forces of any country on active, full-time duty, subject to any right to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, as such Act may be amended from time to time.

Reimbursements after termination of participation in the Plan will be made in accordance with the run-out provisions of Section 4.08 or, if COBRA or other medical continuation coverage is available and elected, Section 3.04.

3.02 Coverage Following Severance

Coverage for an individual shall cease at the end of employment irrespective of any severance agreement.

3.03 Leaves of Absence

An Installed Pastor or Associate Pastor who takes a paid leave of absence from the church shall continue to participate during the leave of absence subject to the same terms and conditions as the Pastor or Associate Pastor had immediately prior to the period of absence.

ARTICLE IV

REIMBURSEMENT BENEFITS

4.01 Provision of Benefits

(a) The benefits available under this Plan for a Plan Year shall take the form of reimbursements for Health Care Expenses Incurred during the Period of Coverage. A Participant shall be entitled to reimbursement under this Plan only for Health Care Expenses incurred after the employee's participation has commenced and before the employee's participation has ceased.

(b) The church shall bear the entire expense of providing the benefits set forth in this Section 4.01. All payments shall be made from the general assets of the church and the appropriate amount identified in the operating budget, however, no assets shall be earmarked or segregated for purposes of providing benefits.

4.02 Limitations on Reimbursements and Forfeitures

Notwithstanding any provision of this Plan to the contrary, the Participant's reimbursement under this Plan for any Plan Year shall be limited to the smallest of the following:

- (a) the Participant's Health Care Expenses for the Plan Year;
- (b) the annual maximum amount described in Section 4.04.
- (c) any limitation established with respect to the Participant pursuant to Section 4.06 or 8.02.

All contributions and limitations on reimbursement shall be prorated to reflect participation during a period shorter than the entire Plan Year.

4.03 Annual Limits

The annual amount that a Pastor or Associate Pastor Participant is to be credited is 6% of effective salary per plan year. Unused amounts may not be carried over to the next Plan Year.

4.04 Expense Reimbursement Procedure

Reimbursement of Health Care Expenses shall be made in accordance with the following rules:

- (a) To receive reimbursement for Health Care Expenses under this Plan, a Participant must submit a written application to the Claim Administrator not later than 30 days following the end of the Plan Year in which such Health Care Expenses were incurred or billed to the Participant
- (b) The Claim Administrator reserves the right to verify to its satisfaction all claimed Health Care Expenses prior to reimbursement.

Each request for reimbursement shall include:

- (i) the name for whom the Health Care Expense was incurred
- (ii) the name of the provider to whom the Health Care Expense was or is to be paid;
- (iii) a statement that the Participant has not been reimbursed nor is reimbursable for the Health Care Expense by insurance or otherwise, and that the Participant has not been allowed a deduction for such Health Care Expense under section 213 of the Code;
- (iv) verification of expense by providing a bill, receipt, canceled check, explanation of benefits or other written evidence of payment or obligation to pay health care expenses.

The Claim Administrator reserves the right to require the Participant to provide, to the Claim Administrator's satisfaction, further proof of any of the above-described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement under the Plan.

4.05 Coordination with Other Sources, Including Flexible Spending Accounts

Reimbursement of Health Care Expenses under this Plan shall be permitted only to the extent that such Health Care Expenses have not been previously reimbursed and are not reimbursable from another source. To the extent that a Health Care Expense is reimbursable from another source, the other source shall provide reimbursement prior to any reimbursement from the HRA Account. For example, if a Participant's Health Care Expenses are covered by both this HRA and the Participant's health flexible spending

account, then this HRA shall not reimburse the Participant for such Health Care Expenses until the amounts available for reimbursement from the Participant's flexible spending account have been exhausted.

4.06 Reimbursement After Termination (Run-Out)

When a Participant ceases to be a Participant in this Plan under Section 2.01 for any reason, the Participant shall not be eligible to be reimbursed from the HRA for Health Care Expenses incurred after the date on which participation terminates. However, such Participant may claim reimbursement for any Health Care Expense incurred during the Period of Coverage prior to termination of participation, provided that the Participant files a claim no later than 60 days following the close of the Period of Coverage in which the Health Care Expense was Incurred.

ARTICLE V

PAYMENT OF BENEFITS

5.01 Application for Benefits

To be entitled to reimbursement under this Plan, a Participant must comply with the rules the Claim Administrator has established for claiming benefits.

5.02 Assignment of Benefits

Except to the extent provided in this Plan, no benefit payable at any time under this Plan shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (e.g., through garnishment, attachment, pledge or bankruptcy): the Plan, the Plan Administrator, the Claim Administrator and the Employer.

5.03 Payment to Representative

In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under this Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Plan remain unpaid, the Plan Administrator may direct the Claim Administrator to make direct payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Plan and the obligations of the Plan Administrator, the Claim Administrator and the Employer.

5.04 Responsibility for Payment

It is the Participant's responsibility, in all cases, to pay for Health Care Expenses. Any benefit payment made directly to a Participant or the Participant's representative (as described in Section 5.03) for a Health Care Expense shall completely discharge all liability of this Plan, the Claim Administrator, the Plan Administrator and the Employer with respect to such expense.

5.05 Overpayments

If, for any reason, any benefit under this Plan is erroneously paid or exceeds the amount payable on account of a Participant's Health Care Expenses, the Participant shall be responsible for refunding the overpayment to the Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under the Plan, or any other method as the Plan Administrator, in its sole discretion, may require.

5.06 Missing Person

If, within two years after any amount becomes payable under this Plan to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of this Plan, provided an appropriate level of care shall have been exercised by the Plan Administrator in attempting to make such payment.

ARTICLE VI
ADMINISTRATION OF THE PLAN

6.01 Administration of the Plan

The [*fill in the name of the person, persons, committee, or entity*] shall serve as Plan Administrator responsible for the administration of the Plan and shall be a named fiduciary of this Plan and shall make all determinations under the eligibility provisions set forth in Article II of the Plan.

6.02 Appointment of Claim Administrator

The [*fill in the name of the person, persons, committee, or entity*] shall serve as the primary Claim Administrator. The Claim Administrator shall have the authority to process all portions of claims under this Plan in accordance with its terms. The Claim Administrator shall have the authority and discretion to interpret the Plan with respect to its duties and to decide questions and disputes arising under the Plan with respect to such duties, which interpretations and decisions shall be final and binding for purposes of the Plan, subject to any right of Participants to appeal the interpretation and decisions under this Plan.

6.03 Powers of the Plan Administrator

The Plan Administrator is specifically given the discretionary authority and such powers as are necessary for the proper administration of this Plan, including, but not limited to, the following:

- (a) to make claim decisions and benefit payments or direct the Claim Administrator to process all or a designated portion of claims and to make benefit payments to or on behalf of Participants entitled to benefits under this Plan;
- (b) to have the authority and discretion to interpret the Plan, to decide questions and disputes, to supply omissions, to correct defects, and to resolve inconsistencies and ambiguities arising under the Plan, which interpretations and decisions shall be final and binding for purposes of this Plan;
- (c) to obtain from Participants and others, such information as shall be necessary for the proper administration of this Plan, such as proof of other coverage and financial data needed to determine if an individual qualifies as the Dependent of an employee (e.g., income tax returns);
- (d) to retain the right, authority, and discretion to make claim payment and benefit decisions upon appeal to the extent it has the authority to make such appeal determinations under Section 6.04;
- (e) to prescribe forms and procedures for enrollment, claim filing, and other administrative purposes under the Plan and to require their use for such purposes and, notwithstanding anything in this Plan to the contrary, to the extent permitted by applicable law, to establish and maintain a procedure whereby any submission requiring a written form may be made telephonically or electronically and whereby submissions made in accordance with such procedure shall be deemed to have been made as if on the applicable written form;
- (f) to adopt rules for the administration of the Plan; and
- (g) to maintain records of administration of the Plan.

No determination of the Plan Administrator or the Claim Administrator in one case shall create a bias or retroactive adjustment in any other case.

6.04 Claims Procedure

The Claim Administrator shall review claims for benefits under this Plan and respond thereto within 30 days after receiving the claim. This period may be extended one time for up to 15 days. The Claim Administrator shall provide to every claimant who is denied a claim for benefits written notification setting forth:

- (a) the specific reason or reasons for the denial;

- (b) specific reference to pertinent Plan provisions upon which the denial is based;
- (c) a description of any additional material or information necessary for the claimant to perfect the claim;
- (d) if an internal rule, guideline, or protocol was relied upon in making the determination, a copy of the rule, guideline, or protocol or a statement that it will be provided free of charge upon request; and
- (e) an explanation of the claim review procedure set forth below.

The claimant or the claimant's duly authorized representative may request a full and fair review of the claim by the Plan Administrator. The claimant's request for review by the Plan Administrator must be submitted to the Plan Administrator in writing within one hundred eighty (180) days of the claimant's receipt of a notice of denial from the Claim Administrator.

The review of a claim by the Plan Administrator shall be subject to the following rules. The claimant or the claimant's duly authorized representative may review pertinent documents and may submit issues and comments, including without limitation appropriate evidence or testimony of an expert, in writing. The review will not afford deference to the initial adverse benefit determination. The review will not be conducted by the individual who made the adverse benefit determination or by that individual's subordinate. The Plan Administrator shall decide promptly, and not later than sixty (60) days after the Plan Administrator's receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, and specific references to the pertinent Plan provisions on which the decision is based.

If the Claim Administrator or Plan Administrator does not decide with respect to a claim within the time limit prescribed by this Section, the claim or appeal of such claim decision shall be deemed denied.

6.05 Records and Reports

The Claim Administrator and Plan Administrator shall maintain all such books, accounts, records and other data as may be necessary for the proper administration of this Plan.

The Plan Administrator shall make available to each Participant for examination at reasonable times during normal business hours such records under the Plan in its possession as pertain to him.

6.06 Fiduciary Duty and Care

All fiduciaries under this Plan, including the Claim Administrator and the Plan Administrator, shall discharge their respective fiduciary responsibilities solely in the interest of the Participants of this Plan for the exclusive purpose of providing benefits to Participants and defraying the reasonable expenses of administering this Plan with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent

person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims and in accordance with the provisions of this Plan.

6.07 Limitation on Liability

A Plan fiduciary shall be entitled to rely upon information from any source assumed reasonably and in good faith to be correct. The Employer, Plan Administrator and Claims Administrator shall not be subject to any liability with respect to his/her duties under this Plan unless it acts fraudulently or in bad faith. No person shall be liable for any breach of fiduciary responsibility resulting from the act or omission to act of any other fiduciary or any person to whom fiduciary responsibilities have been allocated or delegated.

6.08 Indemnification

To the extent permitted by law, the Employer shall indemnify and hold harmless each director, officer, or employee of the Employer to whom fiduciary responsibility with respect to this Plan is allocated or delegated, from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan, other than such liabilities, costs, and expenses as may result from the gross negligence or willful misconduct of any such person or amounts paid by such person in a settlement to which the Employer does not consent. The Employer may obtain, pay for and keep current a policy or policies of insurance, insuring any of its employees who has any fiduciary responsibility with respect to this Plan from and against any and all liabilities, costs, and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities, and obligations under this Plan.

ARTICLE VII
MISCELLANEOUS

7.01 Effect on Employment

Nothing in this Plan shall be construed as a contract of employment between the Employer and any of its employees. Participation in this Plan shall not lessen or otherwise affect the responsibilities of such an employee to perform fully his/her duties in a satisfactory and businesslike manner, nor shall it affect the Employer's right to performance review or seeking dissolution of the relationship from the Presbytery.

7.02 Governing Law

This Plan shall be governed by and construed in accordance with applicable federal laws and, to the extent not superseded, with the laws of the State of Illinois. Benefits provided under this Plan are intended to be exempt from taxation under section 105 of the Code,

and the Plan is intended to comply with any other Code sections as may be applicable to church plans for purposes of retaining such tax exemption.

7.03 Family Medical Leave Act

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Treasury Regulation section 1.125-3.

7.04 Uniform Services Employment and Reemployment Rights Act

Notwithstanding any provision of this Plan to the contrary, contributions, benefits, and service credit with respect to qualified military service shall be provided in accordance with USERRA and the regulations thereunder.

7.05 Invalid Provisions

If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

Executed this _____ day of _____, 20____.

CHURCH NAME

By: _____
Clerk of Session

HRA Reimbursement Request Form

Name of person for whom healthcare was provided_____

Date/s of Service: Beginning Date_____ End Date_____

Claim amount \$_____

Provider _____

() Claim has not and will not be otherwise reimbursed

() Copy of verification of expense attached.



HRA Reimbursement Request Form

Name of person for whom healthcare was provided_____

Date/s of Service: Beginning Date_____ End Date_____

Claim amount \$_____

Provider _____

() Claim has not and will not be otherwise reimbursed

() Copy of verification of expense attached.



HRA Reimbursement Request Form

Name of person for whom healthcare was provided_____

Date/s of Service: Beginning Date_____ End Date_____

Claim amount \$_____

Provider _____

() Claim has not and will not be otherwise reimbursed

() Copy of verification of expense attached.



**Health Reimbursement Arrangement
Enrollment Form**

Name of Employee: _____

Address of Employee: _____

Effective Date of Employment: _____

Dependents:

Name: _____ Relationship: _____
