# Section 125 Church Flexible Benefit Plan

## Employer’s Compensation Account Cash Payment Election Form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 Digits of SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer offers a Cash Payment in lieu of employer-provided medical insurance in the following amount: **$XX.XX per pay.**

I elect to receive the above Cash Payment in lieu of employer-provided medical insurance under my Employer’s Group Health Plan for the plan year beginning on January 1, 20XX and ending on December 31, 20XX (or during such portion of the Plan Year as remains after the date of this election for newly eligible employees).

I currently have medical insurance coverage from the following source and can provide a copy of my insurance card:

Provided by Insured’s Name (ex: spouse or parent): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I am required to provide proof of medical insurance coverage from another source in order to elect Cash Payment (copy of medical insurance card attached). I further understand that by electing Cash Payment I am releasing any right to employer-provided medical insurance. I am solely responsible for keeping myself and my family adequately insured.

In the event the medical insurance coverage that I am receiving from the above named source terminates, I understand that I can prospectively revoke this election and transfer back into the employer-provided medical coverage. I understand that I must request medical insurance coverage from my employer within thirty (30) days of my other coverage terminating. I am solely responsible for any lapse in medical insurance coverage that occurs.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_