# ROMAN CATHOLIC DIOCESE OF BOISE

## CAFETERIA PLAN

## BENEFIT ELECTION AND COMPENSATION REDUCTION AGREEMENT

**NAME:** _____

**ADDRESS:** _____

_____

**SOCIAL SECURITY NUMBER:** _____ - _____ - _____

On the accompanying benefit enrollment form(s), I have enrolled for certain dental and medical benefit coverages.

I elect to receive both my dental and medical benefit coverages under the Roman Catholic Diocese of Boise Cafeteria Plan. Any previous Benefit Election and Compensation Reduction Agreement under the Cafeteria Plan relating to the same benefits is hereby revoked.

I and the Roman Catholic Diocese of Boise 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 _____*, and continuing for each succeeding pay period until this Agreement is amended or terminated. The amount of my required contribution for the benefit options selected is set forth on a schedule that has been provided to me.

I understand that:

-- I cannot change or revoke this Benefit Election and Compensation Reduction Agreement as of any date prior to the next January 1, unless I have a change in the family status (i.e., marriage, divorce, death of a spouse or child, birth or adoption of a child, termination of employment of a spouse and such other events as the Plan Administrator determines will permit a change or revocation of an election).

*The pay reduction may not be effective for any period that begins before you have signed this form and returned it to the Plan Administrator.

-- If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, my pay reduction will automatically be adjusted to reflect that increase or decrease.