

Form 103: Salary Worksheet


This form is to be used for initial eligible employee enrollments, as well as employee salary updates. Accurate and current salary information is necessary for our insurance carrier. In the event a claim is filed for the Long Term Disability benefit, up-to-date salary information is required. For those whose benefit is paid through payroll deduction, the insurance carrier will request information of after-tax payroll deduction at the time a claim is filed.

Employee Full Name	Employee Email Address
_____	_____
Employer Name	Employer Address
_____	_____
Employer Contact Name	Employer Email Address
_____	_____

Combined total of annual salary and housing allowance (if applicable) is considered for premium and benefit:

1. **Gross Annual Base Salary (Line 1)** \$ _____
 - a. Include: salary added for SS offset, salary added in lieu of health insurance, employee retirement salary deferral contributions, and employee payroll-deducted contributions to a HSA or FSA.
 - b. Do Not Include: housing allowance, reimbursements, employer retirement contributions, or other employer paid nontaxable benefits.
2. **Housing Allowance (Line 2)** \$ _____
 - a. Include: Designated housing allowance and/or fair rental value of housing provided by church for qualified pastoral staff.
3. **Total Annual Salary** \$ _____
 - a. Add gross annual base salary and housing allowance amount.

Employer Information [INITIAL ENROLLMENT ONLY]

 This section must be completed by the EMPLOYER per the Form 120: Employer Benefit Agreement

Date of recently updated Form 120: Employer Benefit Agreement: _____
 Changes may only be made once a year during open enrollment and submitted by November 15

LTD Employee Benefit Class: # _____	Life/AD&D Employee Benefit Class: # _____	Life/AD&D Coverage Amount (by class):
		_____ \$10,000
		_____ \$50,000

Premium Payment Calculations

<u>Long Term Disability</u>	<u>Life/AD&D Insurance</u>
.008 (rate) x total annual salary = annual cost / 4 = Cost per quarter	\$10,000 Coverage = \$3.00/month = \$9/quarter
<i>If total annual salary exceeds \$170,000,</i>	\$50,000 Coverage = \$15/month = \$45/quarter
<i>use \$170,000 as your total annual salary in the calculation</i>	

For questions regarding this form, contact FCMM Client Services at (800)995-5357 or benefits@fcmmbenefits.org.

Update Form Submission:

Employer, please submit this completed form to FCMM by mail, secure file exchange, or fax.

Mail:
 FCMM Benefits & Retirement
 901 East 78th
 Street, Minneapolis, MN 55420

Secure File Exchange:
<https://fcmmbenefits.leapfile.net/>

Fax:
 (952)853-8474

For FCMM Office Use Only

FCMM Depositor #: _____ Received Date: _____ Processed by: _____ Processed Date: _____