

**Form 103: Salary Worksheet**

This form is for an eligible employee's initial enrollment (*included in the enrollment packet*) **and** for salary updates. Accurate and current salary information is necessary for our insurance carrier. In the event a claim is filed for the Short Term Disability or 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.

<b>Employee Full Name</b>	<b>Employee Email Address</b>
_____	_____
<b>Employer Name</b>	<b>Employer Address</b>
_____	_____
<b>Employer Contact Name</b>	<b>Employer Email Address</b>
_____	_____

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 Completion [INITIAL ENROLLMENT ONLY]**

This section must be completed by the employer per the most recent *Form 120: Employer Benefit Agreement*. Complete one of the employer pre-determined plan options for the employee listed above.

<p><b>Option 1: Standard Plan (LTD &amp; Life/AD&amp;D)</b></p> <p>LTD Class # _____                  Life&amp;AD&amp;D Class # _____                  Life/AD&amp;D Coverage Amount: _____ \$10,000                    _____ \$50,000                    _____ 1x Annual Salary (1x)</p> <p style="text-align: center;"><b>Premium Payment Calculations</b></p> <p><b>LTD:</b> .008 (rate) x total annual salary = annual cost  <i>If total annual salary exceeds \$170,000, use \$170,000 as your total annual salary.</i>  <b>Life/AD&amp;D:</b>                  \$10,000 Coverage = \$36/annually (.0036 rate)                  \$50,000 Coverage = \$180/annually (.0036 rate)                  1x Coverage = annual salary (rounded to next \$1,000) x .0036 (rate)  <i>If total annual salary exceeds \$120,000, use \$120,000 in calculation.</i></p>	<p><b>Option 2: Plus Plan (STD, LTD &amp; Life/AD&amp;D)</b></p> <p>STD &amp; LTD Class # _____                  Life/AD&amp;D Class # _____                  Life/AD&amp;D Coverage Amount: _____ \$10,000                    _____ \$50,000                    _____ 1x Annual Salary (1x)</p> <p style="text-align: center;"><b>Premium Payment Calculations</b></p> <p><b>STD &amp; LTD:</b> .0092 (rate) x total annual salary = annual cost  <i>If total annual salary exceeds \$170,000, use \$170,000 as your total annual salary.</i>  <b>Life/AD&amp;D:</b>                  \$10,000 Coverage = \$36/annually (.0036 rate)                  \$50,000 Coverage = \$180/annually (.0036 rate)                  1x Coverage = annual salary (rounded to next \$1,000) x .0036 (rate)  <i>If total annual salary exceeds \$120,000, use \$120,000 in calculation.</i></p>
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For questions regarding this form, contact FCMM Client Services at (800)995-5357 or [benefits@fcmmbenefits.org](mailto:benefits@fcmmbenefits.org).

**Form Submission:**

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

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

**Fax:**  
 (952)853-8474

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

<b>FCMM USE ONLY</b>		
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