2019 - DIOCESE OF MAINE
CENTRAL PAYROLL ENROLLMENT/CHANGE INFORMATION FORM

(Please complete a separate form for each enrolled employee)

****An enrollment form must be received each year for every employee participating in Central Payroll****

EFFECTIVE DATE: _____ ***Please circle:*** ***NEW*** ***MAINTENANCE*** ***CHANGE***

EMPLOYEE NAME .....

EMPLOYEE ADDRESS (MAILING).....

.....

PHONE.....E-MAIL.....

SOCIAL SECURITY # .....DATE OF BIRTH .....

CONGREGATION NAME and TOWN of EMPLOYMENT.....

THIS EMPLOYEE IS: CLERGY ____ LAY _____ IF LAY - JOB TITLE.....

IF CLERGY - does employee desire federal and/or state withholding? Yes ___ No ___

Number of hours the employee is expected to work per year _____

Source of Health coverage (e.g. employer-provided Medical Trust, covered by spouse/partner, military, Medicare, other specific type of coverage, or no coverage _____

Level of health coverage - Single,Emp+1, Family_____

For new enrollments or changes in withholding information (lay and clergy) - please fill out a new W-4 (Federal withholding form) and W-4 ME (Maine State withholding form). A completed W-4 must be on file for all employees. If employee is clergy and does not desire withholding, please complete forms, sign and note "no withholding". Clergy please note, FICA is not withheld from your paycheck unless we are instructed to do so.

PLEASE COMPLETE AS APPROPRIATE

I LAY

a ANNUAL SALARY or $_____

b. HOURLY RATE OF PAY/ WEEKLY HOURS (if applicable) $_____/_____hrs

II CLERGY

a. CASH STIPEND $_____

b. SELF EMPLOYMENT TAX REIMBURSEMENT $_____

c.. CASH HOUSING or CASH PARSONAGE ALLOWANCE $_____
(please provide a copy of the resolution)
Housing allowances must be paid through diocesan central payroll for accuracy of W-2 preparation

SALARY REDUCTION INFORMATION - please attach appropriate documentation

Employee Contribution to Retirement Savings $_____ annually (pre-tax)
This amount will be deposited into a qualified 403(b) program of the employee's choice
A signed salary reduction agreement must be on file in the diocesan office

Employee contribution of Medical Insurance **Premium** $_____ annually (pre-tax)

Medical Flexible Spending (Reimbursement Account) $_____ annually (pre-tax)

Dependent Care Flexible Spending (Reimbursement Account) $_____ annually (pre-tax)

Long Term Disability Insurance $_____ annually **(after tax)**

EMPLOYEE SIGNATURE: _____ **DATE:** _____

QUESTIONS: Contact Tom Sumner (ext. 138) - 772-1953 or 1-800-244-6062; tsumner@episcopalmaine.org

These amounts must be verified by the Treasurer's Signature.....

TREASURER'S NAME.....PHONE.....EMAIL.....