

# 2021 - 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**

- 1. EMPLOYEE NAME: \_\_\_\_\_  
.....
- 2. EMPLOYEE ADDRESS (MAILING): \_\_\_\_\_  
.....
- 3. PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_
- 4. SOCIAL SECURITY #: \_\_\_\_\_
- 5. DATE OF BIRTH: \_\_\_\_\_
- 6. CONGREGATION NAME OR TOWN OF EMPLOYMENT: \_\_\_\_\_  
.....

THIS EMPLOYEE IS: CLERGY \_\_\_ LAY \_\_\_ IF LAY - JOB TITLE.....

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)

Health Savings Account Contributions (Reimbursement Account) \$ \_\_\_\_\_ annually (pre-tax)

Short 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](mailto:tsumner@episcopalmaine.org)

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

TREASURER'S NAME: .....

PHONE:.....

EMAIL:.....