MICHIGAN CATHOLIC CONFERENCE

Unit Set-Up and Change Form

Unit/Participating Employer Information *All sections to be completed in full. Use 'Enrollment dates' only if a special enrollment period is required.*

Type of set-up: ☐ New unit/participating employer ☐ Revised benefit plan selections	Effective date *MM/DD/YYYY*	Enrollment dates *MM/DD/YYYY to MM/DD/YYYY*
Unit/participating employer name		Unit number *####*
Address *Street address or PO box, city, state, and zip code*		Federal tax ID *##-#######*
Number of employees	Payroll provider: ☐ Beene Garter ☐ Paycor ☐ Other	Paycor client ID *If applicable*
		☐ Diocesan entity ☐ Listed in Kenedy Directory

Bookkeeper/Business Manager(s) Contact Information

Name *First and last*		Title
Email	Phone *(###) ###-####*	☐ Accesss to Bookkeeper Self-Serve requested
Name *First and last*		Title
Email	Phone *(###) ###-####*	☐ Accesss to Bookkeeper Self-Serve requested
Name *First and last*		Title
Email	Phone *(###) ###-####*	☐ Accesss to Bookkeeper Self-Serve requested

Unit/Participating Employer Benefit Plan Selections

Note: Please check with your Diocese regarding any required MCC programs. Participation agreements may be required for some or all of the employee benefit programs selected.

PPO1 Medical Plan	☐ Add ☐ Drop	**Short Term Disability Plan**	☐ Add ☐ Drop
PPO2 Medical Plan	☐ Add ☐ Drop	**Long Term Disability Plan**	☐ Add ☐ Drop
PPOHD Medical Plan	☐ Add ☐ Drop	**403(b) Retirement Savings Plan**	☐ Add ☐ Drop
BCN Blue Elect Plus Medical Plan	☐ Add ☐ Drop	**Unemployment Insurance**	☐ Add ☐ Drop
Dental Plan	☐ Add ☐ Drop	**Property/Casualty RMP**	☐ Add ☐ Drop
Vision Plan	☐ Add ☐ Drop	**Clergy Automobile Insurance**	☐ Add ☐ Drop
Flexible Spending Accounts	☐ Add ☐ Drop *Includes dependent care FSA, standard health care FSA, and limited purposes health care FSA*		
Life and AD&D Insurance	☐ Add *If adding, select level of coverage:* ☐ 1x ☐ 1.5x ☐ 2x *or* ☐ Drop		
Optional Life Insurance	☐ Add ☐ Drop *Includes employee and dependent life insurance*		
Lay Employees' Retirement Plan	☐ Add *Contact MCC if you wish to stop participation*		

Requestor Information *You must sign and date this form for it to be valid.*

I acknowledge that offering a High Deductible Health Plan (PPO2 and/or PPOHD) requires an employer contribution to an employee Health Savings Account of $50 per month for each employee electing either of these plans.

I understand each unit is required to adopt the Section 125 Church Flexible Benefit Plan as Amended and Restated in order to deduct pre-tax the employee cost share for medical, dental and vision plans and contributions to Flexible Spending Accounts and Health Savings Account.

Name *First and last*	Title
Signature	Date *MM/DD/YYYY*

Rev. 7/14/25

Questions? Please contact Michigan Catholic Conference by phone at (800) 395-5565, fax to (517) 316-3690, or mail to 510 South Capitol Avenue, Lansing, Michigan 48933.
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