NICHOLE M. BRANDON
Director

THE CITY OF COLUMBUS
ANDREW J. GINTHER, MAYOR

DEPARTMENT OF HUMAN RESOURCES

CITY OF COLUMBUS
COMPENSATION REDUCTION AGREEMENT
FOR GROUP BENEFIT PROGRAM

This section to be completed by the employee. Please type or print legibly (illegible forms will be returned)

Employee Name: _____SSN: _____
Date of Hire: _____
Job Class: _____
Bargaining Unit: _____
Department: _____
Division: _____

Purpose of the form:

Section 125 is part of the IRS Code that allows employees to convert a taxable cash benefit (salary) into non-taxable benefits. Under a Section 125 program you may choose to pay for qualified benefit premiums before any taxes are deducted from your paychecks. This form allows you to select the "pre-tax" option for the allowable benefits or keep them on a post-tax basis.

Items you need to understand and agree to:

- You have been provided material on the City's Health Benefit program, (defined as Medical, Prescription Drug, Dental, Vision, and Group life) and hereby certify that you have reviewed and understand the information.
- You have reviewed the personal information and coverage levels for yourself and your dependents (if any), and hereby certify the accuracy. You declare that any dependent for whom you are requesting Medical, Prescription Drug, Dental, and Vision coverage meets the definition and eligibility requirements. You understand and agree that false certification may result in disciplinary action.
- You understand that contributions from your paycheck will be made on the 1st and 2nd paychecks of the month – twenty four (24) times annually, although the City issues paychecks twenty six (26) times annually.
- You understand payroll deductions under this Agreement will continue for each pay period until this Agreement is revoked, amended or otherwise terminated.
- You understand that your compensation reported for tax purposes will be reduced in an amount equal to the rate of contribution for Group Health Program as set by the City's Benefits Wellness Programs or collective bargaining agreement.
- You understand if you have self-identified as a tobacco user, you will be charged an extra $25 the 1st paycheck of the month for the Group Health Program. If you successfully complete the tobacco cessation program (or the reasonable alternative) the surcharge will be removed from your contributions the first of the month after Human Resources and Payroll have been notified.
- You understand that the reduction amount will be automatically adjusted in the event of a change in the contribution rate and that your elections are irrevocable unless you experience a qualifying life event change. Human Resources must receive notification of such change within 30 days.
- You understand the value of the City's Group Health Program coverage for a domestic partner and their dependent children (if any) is considered post-tax contribution on the 1st and 2nd paychecks of the month and that the value of the healthcare cost is imputed income and will be included as taxable wages on form W-2.

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Selections you need to make, if opting out of default pre-tax option. Choose only one.

Post-tax option for full benefit package

☐ I elect to participate in the full benefit package for my employment class. I am eligible for Medical, Prescription Drugs, Dental, Vision, and Group life. By checking this box, I understand that **my future salary will be reduced to pay for my premiums on a post-tax basis** for the Medical, Prescription Drugs, Dental, Vision coverages. Under this option the City pays for my Group Life coverage.

Post-tax option for Domestic Partner (with Children, if applicable) benefit package

☐ I elect to participate in the full benefit package for my employment class. I am eligible for Medical, Prescription Drugs, Dental, Vision, and Group life. By checking this box, I understand that **my future salary will be reduced to pay for my employee premiums on a pre-tax basis, my domestic partner and domestic partner child(ren) if applicable will reduce my salary on a post-tax basis** for the Medical, Prescription Drugs, Dental, Vision coverages. Under this option the City pays for my Group Life coverage.

Waive all coverages except Group Life Insurance

☐ I elect to waive the Medical, Prescription Drug, Dental, and Vision programs but elect to have my Group Life insurance. I understand I will pay $5.50 per month on a post-tax basis to have the Group Life insurance.

Waive all coverages

☐ I do not want to participate in any of the Group Benefit Programs. By checking this box, I understand I will not be enrolled in any group benefit programs, and will not have any contributions deducted from my paycheck.

Signature: _____ Date: _____

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