COMPENSATION REDUCTION AGREEMENT FOR
EMPLOYEE CONTRIBUTIONS FOR GROUP INSURANCE

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

EMPLOYEE #: _____ **AGENCY NAME: _____**

EMPLOYEE NAME: _____ **SSN: XXX-XX- _____**

I hereby certify that I have reviewed and understand the information about the County's insurance program. I have reviewed the personal information and coverage levels for myself and my dependents (if any), and hereby certify the accuracy. I declare that any individual for whom I am requesting health coverage meets the definition and eligibility requirements. I understand that my compensation reported for tax purposes will be reduced in an amount equal to the rate of contribution for this fringe benefit as set by my employer or bargaining agreement. I understand that the reduction amount will be automatically adjusted in the event of a change in this rate.

The money will be taken from the first and second pays of each month, and used to pay for that month's benefits (example – January deductions pay for January insurance coverage). It is my responsibility to review my paycheck advice to ensure the proper amount was deducted. In the event that the payment was not processed, I understand that I am personally responsible for paying my employing agency directly unless instructed otherwise by my agency.

I understand and agree that false certification may result in disciplinary action taken by my employer up to and including dismissal from employment, and possible prosecution.

I understand that my elections may not be changed or voluntarily cancelled at any time during the plan year unless a qualifying status change occurs, as defined by the Plan. The Benefits Office must receive notification of such change within 30 days.

I understand that this compensation reduction agreement for pre-tax and/or after-tax premium contributions will remain in effect and is not revocable, except as noted above.

I understand the value of my employing agency's contribution amount for the healthcare coverage for a domestic partner and/or their dependent children is considered imputed income and that the value will be included as taxable wages on form W-2.

Signature: _____ **Date: _____**

Please Note: Signing this form does not constitute completion of the enrollment process. For help and assistance completing the final enrollment steps visit http://bewell.franklincountyohio.gov/

Please check all that apply:

___ Pre-Tax Employee/Employee + Child(ren)

___ Pre-Tax Employee +Spouse/Employee + Spouse + Child(ren)

___ After-Tax Domestic Partner/Domestic Partner+children (Imputed income/Value to be included as taxable wages on W-2)

(For Agency Use Only)

MUNIS Deduction Code(s): _____ **Effective Date: _____**