2019
CITY OF KETTERING
WAIVER OF INSURANCE FORM

Participation in the health care plan is voluntary. Therefore, with proof of other health care insurance, you can decline to participate in the City's health care plan and receive $3,000 in taxable income distributed over 26 pay periods (pro-rated for mid-year enrollees) from the City.

One of the requirements to receive this additional taxable compensation is that the employee provides proof that he or she and all of his or her tax dependents (including spouse) have other health coverage. Other health coverage for these purposes includes coverage under another group health plan, Medicare or TRICARE. However, coverage under an individual health policy IS NOT considered other health coverage for these purposes.

THEREFORE, IF YOU WANT TO WAIVE COVERAGE UNDER THE CITY'S GROUP HEALTH CARE PLAN IN EXCHANGE FOR ADDITIONAL TAXABLE INCOME, YOU MUST COMPLETE AND SUBMIT THIS FORM WITH THE SUPPORTING DOCUMENTS TO THE PLAN ADMINISTRATOR LOCATED IN THE HUMAN RESOURCES DEPARTMENT. WAIVER PAYMENTS WILL NOT BEGIN UNTIL ALL REQUESTED INFORMATION HAS BEEN RECEIVED BY THE HUMAN RESOURCES DEPARTMENT.

If you and your family waive coverage under the City's group health care plan, you will receive an additional $3,000, less all applicable taxes (pro-rated for mid-year enrollees), only if the employee and all of his or her tax dependents (including spouse) have other health coverage. Other health coverage for these purposes includes coverage under another group health plan, Medicare or TRICARE. However, coverage under an individual health policy IS NOT considered other health coverage for these purposes. This additional amount will be distributed over 26 pay periods. If you or any member of your family participates in the City's group health care plan during the month, you will not receive any additional cash under the Plan for that portion of the month.

According to rules issued by the IRS, once you begin participating in the "Plan" you may not drop out of the "Plan" or vary the amount of your pre-tax contributions until the first day of the next plan year (i.e. each January 1st). However, you may drop out of the "Plan" or vary the amount of your pre-tax contributions under the "Plan" at any time if any of the following qualifying "life events" occur: (i) a change in your legal marital status including marriage, death of a spouse, divorce, legal separation and annulment (ii) a change in the number of your dependents including the birth, death, adoption and placement for adoption of a child (iii) a change in your employment status or a change in your spouse or dependent's employment status including the termination or commencement of employment, a strike, lockout, the commencement or termination of an unpaid leave of absence and change in worksite (iv) a change in you or your spouse's or dependent child's employment status that effects that individual's eligibility under a cafeteria plan (including the Plan) or any benefit plan (including this health plan) (v) your dependent child or spouse satisfied or ceases to satisfy the eligibility requirements because of age, student status or similar circumstances (vi) the commencement or termination of adoption proceedings (vii) a change in your or your spouse's or dependent child's residence that impacts their eligibility under the group health plan (viii) a judgment, decree or court order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that requires coverage under a group health plan for your child or foster child (ix) entitlement or loss of Medicare or Medicaid by you or your spouse or dependent child (x) the commencement or return from a period of absence under the Family and Medical Leave Act (xi) eligibility for COBRA coverage (or similar coverage under state law) offered by the City (xii) any change resulting from a change made under a plan of

your spouse's, former spouse's or dependent child's employer that is listed on this form (xiii) an open enrollment under another employer's plan or (xiv) a special enrollment period under a Federal or state operated health care exchange or marketplace .

If any of these qualifying life events occur, it is important to contact Human Resources in writing, within thirty (30) days to request a special enrollment. Failure to do so will result in the inability to modify benefits elections until Annual Enrollment to be effective the first day of the next plan year.

Again, it is important to note that the IRS has issued these rules and the City must follow the rules. Otherwise, the "Plan" will become disqualified.

IF YOU DO NOT WANT TO PARTICIPATE IN THE HEALTH CARE PLAN, AND INSTEAD CHOOSE TO RECEIVE ADDITIONAL TAXABLE INCOME, YOU MUST COMPLETE AND SUBMIT THIS FORM ALONG WITH ACCEPTABLE PROOF OF OTHER HEALTH CARE COVERAGE FOR YOU AND ALL OF YOUR TAX DEPDNENTS (INCLUDING SPOUSE) TO THE PLAN ADMINISTRATOR.

IF YOU DO NOT SUBMIT THESE FORMS TO THE PLAN ADMINISTRATOR, YOU WILL BE REQUIRED TO ENROLL IN THE CITY'S HEALTH CARE PLAN AND YOUR PORTION OF THE PREMIUMS WILL BE DEDUCTED FROM YOUR COMPENSATION ON A PRE-TAX BASIS AS OUTLINED ABOVE.

If you have any questions, please contact the Plan Administrator immediately at (937) 296-2446.

City of Kettering
Lindsey Patrick, Plan Administrator
Human Resources Department
3600 Shroyer Road
Kettering, Ohio 45429

2019

WAIVER OF HEALTH INSURANCE FORM

Employee's Printed Name **Social Security Number**

Employee's Address **Telephone Number**

Complete the sections below for your spouse and each tax dependent*:

NAME	Source of Other Minimum Essential Coverage** (for example, name of other coverage)

Provide a copy of the proof of the other coverage (e.g. Group Health Plan ID Card, Medicare Card, etc.) for each person (i.e. yourself, your spouse and each of your tax dependents). You will not receive the additional taxable compensation for waiving the Employer's group health plan unless you provide this proof. Note that the additional taxable compensation will be paid in accordance with the Employer's normal payroll practices and will be subject to all applicable withholdings. No payment will be made if the Employer knows or has reason to know that you have not complied with all the requirements. You must complete this form and supply the requested proof each year.

Employee's Signature **Date**

Employee's Printed Name **Department**

If you have any questions, please contact the Plan Administrator immediately at (937) 296-2446.

***Tax Dependent includes all individuals for whom you reasonably expect to claim as a personal exemption deduction for the taxable year in which you are waiving City insurance and receiving the taxable waiver payment.**

****Minimum Essential Coverage does not include coverage purchased in the individual market, whether or not obtained through the Marketplace.**