

**2012**  
**CITY OF KETTERING**  
**PREMIUM ONLY PLAN ENROLLMENT NOTICE/  
WAIVER OF INSURANCE FORM**

The City of Kettering has established the City of Kettering Cafeteria Plan (the "Plan"), which has been modified, in part, to allow you to pay your portion of the premiums for the City's health care plan on a pre-tax basis. In other words, your portion of the health plan premiums will be deducted from your pay twice per month pre-tax. This means the amount you pay for the premiums will not be subject to federal and state income tax. As a result, you realize an immediate tax savings through the "Plan."

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 HDHP health care plan and receive \$3,000 in taxable income distributed over 26 pay periods (pro-rated for mid-year enrollees) from the City. However, if you elect to participate in the City's HDHP health care plan, you automatically will participate in the payroll deduction plan.

**THEREFORE, IF YOU WANT TO WAIVE COVERAGE UNDER THE CITY'S HDHP 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 RESOURCE DEPARTMENT.**

If you and your family waive coverage under the City's HDHP group health care plan, you will receive an additional \$3,000, less all applicable taxes (pro-rated for mid-year enrollees). This additional amount will be distributed over 26 pay periods. If you or any member of your family participates in the City's HDHP 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 of 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.

**If any of these qualifying “life events” occur, it is imperative that you contact the Plan Administrator in writing, within thirty days. If you do not contact the Plan Administrator in writing within thirty days, you will not be able to modify your election under the “Plan” until the first day of the next plan year.** The Plan Administrator will provide you a Change in Election Form for you to complete once you notify the Plan Administrator that one of these events has occurred.

In addition, if there is an insignificant change in the amount of premiums for the HDHP group health care plan during the plan year, the amount you are contributing under the “Plan” automatically will be adjusted to reflect the change. On the other hand, if there is a significant increase in the cost of the coverage or coverage under the health care plan is significantly changed or ceases during the plan year, you may revoke your election under the “Plan.” Also, if a new benefit is added during the plan year, you may elect coverage under the newly-added option for the remainder of the 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 HDHP HEALTH CARE PLAN, AND INSTEAD CHOOSE TO RECEIVE ADDITIONAL TAXABLE INCOME, YOU MUST COMPLETE AND SUBMIT THIS FORM ALONG WITH PROOF OF OTHER HEALTH CARE COVERAGE TO THE PLAN ADMINISTRATOR NO LATER THAN NOVEMBER 23, 2011.**

**IF YOU DO NOT SUBMIT THESE FORMS TO THE PLAN ADMINISTRATOR BY NOVEMBER 23, 2011, YOU WILL BE REQUIRED TO ENROLL IN THE CITY’S HDHP 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  
Gayle L. Garrison, Plan Administrator  
Human Resources Department  
3600 Shroyer Road  
Kettering, Ohio 45429

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**2012**  
**WAIVER OF HDHP HEALTH INSURANCE FORM**

I have read and understand the information explaining my rights to participate in the City's group HDHP health care plan, and I have elected to waive coverage under the City's group HDHP health care plan in exchange for additional taxable cash compensation.

\_\_\_\_\_  
Employee's Printed Name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

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I am attaching the following documents to prove that I have other health care coverage:

\_\_\_\_\_  
Name of Policy Holder

\_\_\_\_\_  
Policy Holder SS Number

\_\_\_\_\_  
Your Relationship to Policy Holder

\_\_\_\_\_  
Insurance Plan

**By signing this waiver, I understand that I am waiving coverage under the City's group HDHP health care plan and that I may not be able to enter the City's group HDHP health care plan unless I comply with the rules explained in this document.**

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Human Resources Department  
3600 Shroyer Road  
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