



CITY OF REDDING
INTERNAL COMMUNICATION

Date: April 15, 2014

To: Employee

FROM: Sheri DeMaagd, Personnel Director

SUBJECT: 2014 Election Form for City of Redding Section 125 Plan – Health Premiums

Please complete the form below and return to the Personnel Department by May 15, 2014.
 The employee contribution rate is as follows:

IBEW Maintenance, RPOA Miscellaneous, RIEO – CTP and Supervisory/Confidential:

2014 Composite Premium*	10% Monthly Employee Contribution	Per Pay Period Employee Contribution
\$1525	\$152	\$70.36

RPOA, IAFF, RPMA, IBEW Electric, UPEC and Unrepresented Employees

Two plans available: the Base Plan and the Premium Plan:

2014 Composite Premium – Base Plan*	10% Monthly Employee Contribution	Per Pay Period Employee Contribution
\$1421.00	\$142.00	\$65.45
2014 Composite Premium-Premium Plan*	Monthly Employee Contribution	Per Pay Period Employee Contribution
\$1525.00	\$246.00	\$113.54

*Note: The Composite Premiums will change in January of each year.

Plan Year June 1, 2014 - May 31, 2015

Please elect or waive Section 125 Plan Coverage by placing your initials or an “x” on the line next to the appropriate section below, and sign and date at the bottom.

_____ I elect to enroll in the City of Redding Section 125 Plan. I authorize City of Redding to reduce my compensation **before-tax** in an amount equal to the contribution required by City of Redding for this coverage, per the Section 125 Plan Document. The monthly amount of contribution is subject to change at the discretion of City of Redding; however, I will be notified in advance of any changes.

_____ I elect **not** to enroll in the City of Redding Section 125 Plan. I understand that this means I will pay insurance premiums on an **after-tax** basis.

I, and the City of Redding, agree that:

- A. I have been made fully aware of the benefits and conditions of the City of Redding Section 125 Plan, and have been informed that the formal plan document is on file in Personnel Department and is available for my inspection and use.
- B. I have received notification of how my coverage choice may affect my earnings.
- C. This election is effective for the Plan Year indicated and cannot be revoked unless there is a change in family status as permitted by IRS regulations.

Employee Signature _____

Date _____