Dental and Vision Insurance Election Form
1/1/25 thru 12/31/25

Please select one box below to indicate your Dental insurance election and one box to indicate your Vision insurance election. The deductions shown next to the benefits that you select will be deducted from each of your paychecks before taxes under our section 125 plan.

Dental Coverage Choices:

Employee Only	☐	$13.47 per paycheck
Employee and Spouse	☐	$29.42 per paycheck
Employee and Children	☐	$34.70 per paycheck
Family	☐	$52.72 per paycheck
Waiving Dental Coverage	☐	

Vision Coverage Choices:

Employee Only	☐	$2.94 per paycheck
Employee and Spouse	☐	$4.95 per paycheck
Employee and Children	☐	$5.05 per paycheck
Family	☐	$8.15 per paycheck
Waiving Vision Coverage	☐	

SALARY REDUCTION AGREEMENT

I have read and understand the explanation that I have received regarding my options under the Columbus International Corp. Premium Only Plan. Columbus International Corp. (CIC) will redirect my salary as needed on a pretax basis during the plan year and apply this amount toward purchasing the coverage I have elected above. I also understand that my election is irrevocable unless there is a change in my status. A change in status includes: marriage; divorce; death of a spouse or dependent; birth or adoption of a child; change in the number of dependents; termination or commencement of employment; a change in residendence for me, my spouse or children or a change in my spouse's employment status. I hereby apply for the coverage that I have elected above and authorize CIC to adjust my pay as required by my elections from January 1, 2025 through December 31, 2025.

Signature _____ Date _____

Name (please print) _____

Phone _____

Email _____

Mailing Address _____

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