

Independent Healthcare Staffing Insurance/Deduction Authorization

Employee Name _____ Social Security # _____

**Insurance benefits begin on the first day of your assignment (Plan Effective Date) and ends
on the last day of your assignment .Please make your selection and sign below.**

		<i>weekly deduction</i>
No Coverage	To decline coverage check this box and sign on the signature line below	<input type="checkbox"/>

Employee Only	Medical and Dental	\$0.00	<input type="checkbox"/>
Employee/Spouse	Medical and Dental	\$103.00	<input type="checkbox"/>
Employee/Child(ren)	Medical and Dental	\$78.75	<input type="checkbox"/>
Emp/Sp/Child(ren)	Medical and Dental	\$183.50	<input type="checkbox"/>

To maintain eligibility, employees must work a minimum of 30 hours per 1 week pay period. IHS pays the entire premium for Single coverage or the equivalent towards other coverage when an employee maintains 36 (or 40) hours per 1 week pay period, based on contracted hours. If the hours worked fall short of contracted hours, \$3.08 per hour will be deducted for each hour short of 36 (or 40). IHS has the authorization to deduct for insurance premiums in addition to employment agreement items.

AUTHORIZATION

I authorize the adjustment to my base salary based on the elections on this form. I understand that by signing and submitting this form I am making a binding election for the plan year as stated unless such revocation or new election is on account of and consistent with a qualifying change in status. I further understand that this form must be signed and dated prior to the Plan Effective Date in order to be eligible to participate in this plan year.

Signature _____ Date _____

DECLINATION

The benefits of the plan have been thoroughly explained to me and I decline to participate. I understand that I cannot enroll until the beginning of the next open enrollment period or until I experience a qualifying change in status that would allow me to change my election.

Signature _____ Date _____