Independent Healthcare Staffing

Insurance/Deduction Authorization

Employee Name ______________________ Social Security # ____________________

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

		weekly deduction	
No Coverage	To decline coverage check this box and sign on the signature line below	Decline	☐

Employee Only	**Medical and Dental (2000.00 Deductible)**	**$0.00**	☐
Employee Only	Medical and Dental (500.00 Deductible)	$11.11	☐
Employee/Spouse	**Medical and Dental (2000.00 Deductible)**	$98.18	☐
Employee/Spouse	Medical and Dental (500.00 Deductible)	$122.94	☐
Employee/Child(ren)	**Medical and Dental (2000.00 Deductible)**	$73.10	☐
Employee/Child(ren)	Medical and Dental (500.00 Deductible)	$93.66	☐
Employee/Family	**Medical and Dental (2000.00 Deductible)**	182.77	☐
Employee/Child(ren)	Medical and Dental (500.00 Deductible)	$218.33	☐

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 addtion 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 ____________________