Independent Healthcare Staffing

Insurance/Deduction Authorization

Employee Name _____ **Social Security #** _____

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

No Coverage	**To decline coverage check this box and sign on the signature line below**		☐
		weekly deduction	
Employee Only	**Medical (2000.00 Deductible)**	**$0.00**	☐
	Medical (500.00 Deductible)	$12.71	☐
	Dental Low Option	$0.00	☐
	Dental High Option	$0.00	☐
Employee/Spouse	**Medical (2000.00 Deductible)**	**$95.12**	☐
	Medical (500.00 Deductible)	$123.08	☐
	Dental Low Option	$3.87	☐
	Dental High Option	$7.25	☐
Employee/Child(ren)	**Medical (2000.00 Deductible)**	**$67.37**	☐
	Medical (500.00 Deductible)	$90.89	☐
	Dental Low Option	$4.98	☐
	Dental High Option	$9.16	☐
Employee /Family	**Medical (2000.00 Deductible)**	**$174.38**	☐
	Medical (500.00 Deductible)	$215.06	☐
	Dental Low Option	$8.86	☐
	Dental High Option	$16.41	☐

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. IHS has the authorization to deduct for insurance premiumsin 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** _____