Medical Benefits Eligibility:

Eligibility Requirements:

1. **Employment Duration:**
   Temporary employment agency staff are eligible to enroll in medical benefits after completing 60 calendar days of continuous employment.
2. **Minimum Hours Requirement:**
   To qualify for medical benefits enrollment, temporary staff must work a minimum of 30 hours per calendar month during the 60-day eligibility period.
3. **Verification of Hours:**
   Hours worked will be reviewed and verified by the Human Resources (HR) department. Staff who do not meet the minimum 30 hour threshold during the 60-day calendar period will not be eligible for medical benefits until they meet this requirement in the open enrollment period .

Enrollment Process:

1. **Notification of Eligibility:**
   After the 60-day eligibility period and verification of hours worked, eligible staff will receive a notification from the HR department regarding their qualification for medical benefits enrollment.
2. **Enrollment Window:**
   Once notified, eligible staff will have 30 days to enroll in the company's medical benefits plan. Failure to enroll within this window will result in forfeiture of the opportunity to enroll until the next open enrollment period, or a qualifying life event.
3. **Benefit Effective Date:**
   Medical benefits will become effective on the first of the month prior to enrollment
4. **Employees must maintain the minimum of 30 hours worked per calendar month to be eligible for medical benefits.**
5. Please contact HR for additional information.

Please let us know if you are interested in this benefit at the initial interview process or sign the waiver form attached.

ENROLLMENT FORM

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A. REQUIRED EMPLOYEE INFORMATION
Complete the Enrollment Form and return to your Human Resources Department.

Name:		Phone:
Social Security #:	Date of Birth:	Sex: ☐ Male ☐ Female
Address:		Apt. #:
City:	State:	Zip:
Hire Date:	Employee ID:	

B. MEDICAL BENEFIT PLAN SELECTION
Payroll Deducted Rates - Please select the tier for each product in which you wish to enroll.

☐ MEC PLAN	COST
☐ Employee Only	$49.00
☐ Employee + Child(ren)	$75.80
☐ Employee + Spouse	$78.20
☐ Employee + Family	$105.00

MVP COMPLIANCE PLAN — Please call 1.844.300.6497 to enroll.

C. REQUIRED DEPENDENT INFORMATION

Name	Social Security #	Date of Birth	Sex	Relationship
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner
			☐ M ☐ F	☐ Spouse ☐ Child ☐ Domestic Partner

Any changes made to the Enrollment Form will require the changes to be dated and initialed by employee.

ACKNOWLEDGEMENT & WAIVER FORM

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D. REQUIRED SIGNATURE You MUST sign and date to be enrolled in coverage

Election of Coverage: I have read and understand the coverage options I have elected. I understand completion of this enrollment form in no way implies I will be accepted for coverage. I understand coverage will take effect only if this enrollment form is approved by the plan sponsor and the plan has been properly funded, provided I meet any eligibility or coverage effective date requirements listed in the plan documents.

☐ Accept coverage options as selected

Date: Signature:

E. REQUIRED SIGNATURE You MUST sign and date if you wish to decline coverage.

Waiver of Coverage: I, the undersigned employee, understand and acknowledge that: I have been offered an opportunity by my Employer to enroll in affordable employer-sponsored health coverage that meets the minimum value standard set forth in the Patient Protection and Affordable Care Act (ACA) for the applicable period:

- I will not qualify for government credits and subsidies to purchase individual health insurance on a state or federal marketplace or exchange
- I may not cover dependents under the Employer's plan, and
- I may not be able to enroll in the Employer's plan until the next open enrollment, except in a qualified change in status or other limited circumstances.

☐ Decline all coverage options

Date: Signature: