

Please sign and return this form

INTRASTAFF

A subsidiary of
Johns Hopkins Health System

MEDICAL/DENTAL HEALTH CARE BENEFITS INFORMATION OPTION FORM

Intrastaff offers health care benefits from Johns Hopkins Employer Health Programs (“EHP”) to employees with at least thirty days of service **and** who work an average of thirty six hours per week at a 50% subsidized cost for individual coverage. Open enrollment is annually every Fall and benefits begin on January 1.

SUMMARIZED POINTS OF INTEREST REGARDING BENEFIT INFORMATION

- Benefits begin on the first day of the month following date of hire, provided a completed enrollment form has been received within 30 days of the employment date.
- The insurance premiums are deducted weekly by Intrastaff on a pre-tax basis.
- Should the hourly average of hours worked not meet the criteria of 36 hours per week (averaged over 12 weeks), I understand the insurance benefits will be cancelled. Coverage will run through the last day of the month in which it was cancelled.
- If an employee does not receive a paycheck for one week, he/she is still responsible for paying the premium to Intrastaff. If an employee does not receive a paycheck for two weeks or more, the insurance will be cancelled but coverage will run through the last day of the month in which it was cancelled, and any due premiums will be still owed to Intrastaff by the employee.
- Status of insurance cannot be changed during the calendar year and can only be changed (to enroll in or to cancel) during the annual open enrollment period.
- Upon separation or insurance cancellation, insurance may be purchased through COBRA for a total of 18 months. Information will be sent to you in the mail upon separation or cancellation.

Please check one of the following choices:

- I **plan to enroll** in the health care benefit package mentioned above. Please process my completed application which is attached to this form.
- I **wish to waive** the health care benefit package at this time. However, I understand that I will not be eligible to enroll in the benefit package until the next enrollment period, which is annually January 1.

I have read the above information and understand the information offered to me.

Please print name here

Signature here

Date