Full-time Employee Election/Waiver of Group Insurance Participation

Company: Loving Care Home Care, LLC

Full-time employees must use this form to either elect to participate in the Health Insurance Program or waive health insurance coverage.

Employee Name: ____

Employee SS#:____

The Health Insurance premium is 9.5% of your weekly earnings. You must work at least 30 hours per week within a 90 day period of your hire date. Part-Time employees are eligible for Health Insurance at the full premium rate. Wayne County Health Choice is the insurance provider. Dependents are eligible to be covered under the Health Insurance Plan.

Please indicate your choice below and sign.

____ **YES**, I do want to participate in the coverage and understand I will be responsible for the coverage premiums at 9.5% of my bi-weekly earnings. Health Insurance Coverage is provided by Wayne County Health Choice.

____ Health Insurance (Employee Only)

____ **NO,** I do not wish to participate in the Company's Health Insurance Program. I understand that I cannot change this election until the next enrollment period or until I experience a Qualifying Change in Status which would allow me to enroll in the Company's Health Insurance Program. You have the option to elect insurance from the Health Care Exchange at https://www.healthcare.gov/ during the open enrollment period or when a life changing event allows you to enroll in the Health Care Exchange. You also have the option of joining your spouse's company's health insurance plan if you qualify. I acknowledge that I have received a copy of the New Health Insurance Marketplace Coverage Options and Your Health Coverage Part A & Part B.

____   _________________

Signature of Employee   Date

____   _________________

Signature of Group Insurance Representative   Date