

# BENEFITS ACKNOWLEDGMENT

## PLEASE INITIAL EACH OF THE STATEMENTS BELOW TO ACKNOWLEDGE THE FOLLOWING:

I understand that I have been given an offer of health care coverage, including medical coverage, by my employer. I have received the summary of the benefit plans that explains the offer of this coverage and understand that I am eligible to enroll in health care coverage following the applicable waiting period (*which is the first of the month coinciding with or following my hire date*).

I have received the notice titled "New Health Insurance Marketplace Coverage Options and Your Health Coverage." I understand that this notice indicates that my employer is offering me a medical plan that meets the requirements of Minimum Value (*as defined in the notice*) and is intended to be affordable based on my wages.

I understand that if my employer offers me the Minimum Value coverage noted above and that coverage is affordable based on my wages that I am not eligible for a premium tax credit from any state or federal healthcare marketplaces. If I receive a premium tax credit I am not eligible for, I will need to refund the government for the credits. For more information on eligibility for premium tax credits, I can go to: [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Premium-Tax-Credit](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Premium-Tax-Credit).

I have received a Summary of Benefits and Coverage describing the medical benefits available to me. I understand that this Summary of Benefits and Coverage indicates that my employer is offering me a medical plan that meets the requirements of Minimum Value (*as defined in the Summary of Benefits and Coverage*).

I acknowledge the Benefits Guide I received is only a summary of the benefits. Complete descriptions of the plans are contained in the applicable plan documents. If there is any disagreement between the Benefits Guide, this acknowledgment and the wording of the applicable contract or plan document, the contract or plan document will govern. Allegis Group, Inc. and its operating companies reserve the right to modify, amend, suspend, or terminate any plan in whole or in part, at any time.

I understand that I may access more information about the medical benefits available to me at any time by visiting [www.AllegisMarketplace.com](http://www.AllegisMarketplace.com) or by calling **1-866-886-9798** to request a paper copy of relevant documents at any time free of charge.

I acknowledge that if I choose to participate in the benefits for which I am eligible, I will need to visit [www.AllegisMarketplace.com](http://www.AllegisMarketplace.com) or complete the required paper enrollment forms to enroll.

## THIS ACKNOWLEDGMENT DOES NOT CONSTITUTE A GUARANTEE OF EMPLOYMENT.

*Please Note: If you enroll in benefits during the first month in which you are eligible to participate, your enrollment will be retroactive to the first of the month and you will be double deducted from your paycheck for any missed weekly premiums.*

Printed Name of Employee: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_ Date: \_\_\_\_\_