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**HEALTH, DENTAL AND VISION INSURANCE**

Group health, dental and vision insurance are available to all regular, full-time employees. If an employee elects to participate, health insurance coverage, dental insurance coverage and vision insurance coverage begin the first day of the month following the date of hire. For health insurance premiums, dental insurance premiums and vision insurance premiums, Resilient Solutions 21 will pay one-half of the premiums for the employee; the employee is responsible for the remaining one-half. The Company will pay the entire premium and recover the employee portion through payroll deduction. Should an employee terminate employment with Resilient Solutions 21, coverage will continue through the end of the month in which the last day of employment occurs, with appropriate deductions for premiums made from the final paycheck.

In the event an employee leaves Resilient Solutions 21 and was enrolled on the medical plan, employees can continue coverage for up to 6 months after they are gone. They would need to contact the health insurance provider in order to make this happen.

**AUTHORIZATION FOR PAYROLL DEDUCTION**

*Section 1: Participant Information – All employees must complete this section in its entirety.*

First Name:

Last Name:

SSN:

Home Address:

City, State, Zip:

Date of Birth:

Date of Hire:

*Section 2: Add Payroll Deductions – Employer completes this section*

Health Insurance Benefit:

Level of Coverage:

Biweekly Payroll Deduction:

Effective Date:

Vision Insurance Benefit:

Level of Coverage:

Biweekly Payroll Deduction:

Effective Date:

Dental Insurance Benefit:

Level of Coverage:

Biweekly Payroll Deduction:

Effective Date:

I authorize the above pre-tax deductions to be deducted from my pay each payday. I authorize deduction rate increases or changes as requested by the vendor in accordance with the terms and conditions of my policies.

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

Employer Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_