



The UNIVERSITY of VERMONT

Human Resources Benefits Office

Full-time Employees with Two Person or Family Coverage Waiver of Medical Coverage (This is a sworn statement & must be done annually)

Name: _____ SSN: _____
Last First M.I.

Campus Address: _____ Work Phone: _____

Name of Spouse: _____

Please check here if your spouse or civil union partner is an employee of the UVM.

Name and Ages of Other Dependents: _____

Name of Employer (other than the University of Vermont) providing group health coverage: _____

Name of Insurance Carrier for other group health coverage: _____

I hereby elect to receive \$1,000* in lieu of coverage under the University of Vermont's group health plan and swear that all of my dependents and I are covered by the group health coverage described above. I hereby waive for myself and my dependents group health coverage under the University of Vermont's group health plan. I understand that I will not be allowed to change this election until the next annual open enrollment unless there is a change in my family status as defined by the IRS and described in the FSA Summary Plan Descriptions booklet. I acknowledge that my waiver of medical coverage will be paid to me on a prorated basis**, based on how many paychecks I receive during the calendar year. This waiver will remain in effect until I rescind it by applying for medical coverage within 30 days of losing my medical coverage with my other insurance carrier.

Sworn Signature: _____ Date: _____

Please provide a photocopy of your group ID card or other evidence of group medical insurance coverage.

- * You are not eligible for the \$1,000 waiver if:
• your spouse is also an employee of the University of Vermont
• you or your dependents have Medicare or Medicaid
• you or your dependents are on COBRA
• you or your dependents have an individual plan

** The \$1,000 waiver is prorated based on the length of time actually employed during the calendar year.