This form must be completed if you are choosing to NOT ENROLL in UVM's Medical Benefits.

Send completed form to Human Resource Services via: uvm.edu/filetransfer to HRSinfo@uvm.edu

Employee ID: _____

Waiver of Health Care Coverage

This sworn statement must be completed upon initial waiver of health care coverage and each calendar year during Open Enrollment.

Employee Name: _____ Effective date: _____

Address: _____ Work phone: _____

Name of Spouse: _____

UVM has offered me health care coverage, and I have **NOT** accepted because:
(select one)

My coverage is provided through: _____

I understand I am NOT eligible for the $1,000 waiver because (review and select if applicable):

- ☐ I am an employee working less than full-time
- ☐ I am the spouse/dependent of a UVM Employee and am covered by their health care coverage
- ☐ I am employed by and have health care coverage through UVMMC
- ☐ I have Medicaid or Medicare
- ☐ I have CORBA
- ☐ I have declined UVM health care coverage and do not have other health care coverage

Signature: _____ Date: _____

I have reviewed the above and am eligible to receive $1,000* in lieu of coverage under the University of Vermont's group health plan and swear that all my dependents and I are covered by the group health coverage described above and we hereby waive our health care 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 Description. Any future change request tied to a change in family status must be made within 20 days of losing health care coverage with my insurance carrier. I acknowledge that my waiver of health care coverage will be paid to me on the prorated basis** based on the number of paychecks I receive during the calendar year.

This form must be completed annually in order to receive the $1,000 waiver reimbursement. An employee whose spouse or civil union partner works at the University is not eligible for this waiver of health care coverage.

Signature: _____ Date: _____

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

Please note: Eligible United Academic Full-time bargaining unit employees are eligible for the medical waiver credit after 2 completed semesters at the University