Do not use this form for Open Enrollment. Open enrollment elections must be submitted via PeopleSoft Self-Service.

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 HRinfo@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 dependent of a UVM Employee and am covered by their health care coverage
- ☐ I am employed full-time and have health care coverage through UVMMC *(does not apply to UVM Staff United)*
- ☐ I have COBRA
- ☐ I have declined UVM health care coverage and do not have other health care coverage

Sign here to acknowledge you are NOT eligible for the waiver payment for one of the reasons listed above:

Signature: _____ Date: _____

I have reviewed the above reasons that would make me ineligible for the waiver payment. Further, I can confirm I 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 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 Medical 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.

Sign here to acknowledge that you are eligible for the waiver payment:

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