The University of Vermont
Human Resource Services

EmplID: _____

Waiver of Dental Coverage

Name: _____
Last First

Birth Date: _____

Hire Date: _____

Work Phone: _____

Effective Date: _____

☐ **Check here if your spouse or civil union partner is an employee of UVM**

Name of Spouse: _____

☐ **Check here if you are employed by and have medical coverage through UVMMC**

Name and Age of Other Dependents: _____

_____

_____

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 dental coverage with my insurance carrier.

Sworn Signature: _____ **Date**: _____

Updated October 2016