Sworn Statement of Alternative Health Insurance Coverage

Name:	Social Security Number:

The District Cafeteria Plan requires that you enroll in their group health insurance plan, unless you receive comparable alternative group health insurance coverage. If you have comparable alternative coverage, please complete the following, sign and return this form with proof of alternate permissible health plan coverage for yourself and, if applicable your spouse and eligible tax dependents to Human Resources. ***Enrollment in an "individually purchased plan," such as coverage from Vermont Health Connect is not an eligible alternative health insurance plan.*** Permissible health plan coverage may include Employer-sponsored plans, Medicare, Medicaid, CHIP, TRICARE, VA Coverage, Coverage for Peace Corps volunteers, or Civilian Employees of the U.S. Department of Defense.

Alternative Coverage
Plan Sponsor:
Insurance Company:
My coverage: (select one): ☐ Single; ☐ 2 Person; ☐ Family;
Effective for the 12-Month Period Beginning (Plan Year effective date): **Provide a copy of your health insurance ID Card and/or cards***

I certify that I am currently receiving comparable medical benefits as listed above. To the best of my knowledge this coverage is comparable to the health insurance provided by my employer. I understand that the Plan Administrator reserves the right to refuse this statement based on a finding that the alternative coverage is not comparable.

*I understand that I will not receive the "cash in lieu" if I do not supply proof of insurance coverage (health insurance ID Card and or other information as requested) for myself and, if applicable, my spouse and tax dependents. I understand that if my health insurance status changes during the Plan Year (January 1 – December 31), I must notify the District Human Resources department within 30 days.

Under penalty of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Employee's Signature:	Date:
Authorized Delegate of the Plan Administrator:	Date:

Acceptable proof of alternative coverage shall include a copy of the employee's alternative medical insurance ID card indicating the employee's name as a dependent; a letter from the spouse/civil union partner's employer indicating the employee, spouse and dependents are covered under the plan; or, a letter from the alternative insurance carrier indicating proof of coverage.

IF YOU ARE A TEACHER OR AFSCME MEMBER AND ARE ELIGIBLE PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM. ⟹

Barre Unified Union School District ("District") Cafeteria Plan

Cash-in-lieu of Insurance Election of Benefits Form

(AFSCME MEMBERS, TEACHERS, ADMINISTRATORS & NON CONTRACTED EMPLOYEES ONLY)

Provisions of Act 7 as defined by 16 V.S.A. Chapter 61 states that school employees cannot receive CIL of health benefits if receiving health benefits from a school employer.

Name (Last, First MI)	Date
Social Security Number	Plan Year

Election to receive Employer Contribution as Cash

I am eligible for the Employer contribution because I am employed by the BUUSD under the American Federation of State, Country and Municipal Employees (AFSCME) or the Barre Education Association (teacher only) collective bargaining agreement and I am not electing health insurance benefits through the District (which I am eligible for), and I have other permissible health plan coverage for myself, and if applicable, my spouse and eligible tax dependents. (Please refer to the Sworn State of Alternative Health Coverage below for more details.)

I understand I will receive the employer contribution in one installment. Payment will be made at the end of Fiscal Year (June 30th of each Fiscal Year), on dates to be selected by my employer, **to be taxed as regular income**.

This agreement is subject to the terms of the District Cafeteria Plan, as amended from time to time in effect, shall be governed and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election relating to such plan.

This election form is only valid for the Plan Year specified above. A new election must be made each Plan Year in which the employee wishes to participate.

A Sworn Statement of Alternative Health Insurance and proof of alternative insurance for the employee and all tax dependents must accompany this election form.

Employee's Signature:	Date:

Please complete the *Sworn Statement of Alternative Health Insurance Coverage* on the reverse side of this form ⟹