OFFICE OF HUMAN RESOURCES
UTICA UNIVERSITY
HEALTH INSURANCE WAIVER BUYOUT PLAN

Utica University offers a Health Insurance Waiver Buyout Plan to benefit eligible employees who opt not to take health insurance coverage because they are covered under an alternate plan.

PLAN OVERVIEW:

Utica University offers health insurance to eligible employees. Many employees have similar coverage options through outside professional groups/organizations/associations, a secondary employer, or a spouse's employer or a parent.

For those employees who have alternative health insurance coverage, Utica University has a Waiver Buyout Plan through which the University will make a once a year annual lump-sum payment, payable in December of each year, to employees who have waived membership in a Utica University health insurance plan.

RULES & REGULATIONS:

If an eligible employee (after a careful review of other insurance coverage available to them through alternate carriers) decides to take advantage of the "Waiver" plan, they must comply with the following regulations to be eligible for the annual buyout:

1. The employee must sign a properly completed waiver and be off the Utica University Health Insurance plans for eleven consecutive months (January through November) prior to the date of payment. Payments will be made in December of each calendar year.

2. Employees who agree to join the "Waiver" plan must surrender all current Utica University hospitalization and major medical identification cards to the Human Resource Office on the day following the last day of effective insurance coverage. If cards are not surrendered, the "Waiver" will be considered invalid, and the employee will lose the buyout payment opportunity.

3. Enrollment in the "Waiver" plan will be considered valid only upon receipt of the "Waiver" form in the Human Resource Office during the open enrollment period (generally held in November.) Note: it is incumbent upon the individual employee to complete a "Waiver" form each year.

4. If, during the course of the year, circumstances change and an employee experiences a "qualifying event"* in which alternative coverage is no longer available, the employee may enroll in any of the University plans. **However, no prorated payment will be made.**

5. **Please attach a copy of your insurance card. Utica University requires proof of alternate insurance such as a copy of your insurance card.**

If an employee opts to take advantage of this program, payment will be made as follows:

IF AN EMPLOYEE IS ELIGIBLE FOR:	***ANNUAL PAYMENT WILL BE:***
Individual	$500.00
Subscriber & One	$800.00
Family	$1,000.00

If an employee wishes to participate in the Waiver Buyout Plan, they would be able to do so during the University open enrollment. Eligibility for individual, family or subscriber and minor coverage will be determined at the time of "Waiver". This benefit is extended to eligible employees whose spouse/domestic partner currently works at Utica University; the benefit in this instance is limited to the Individual Plan rate.

*Examples of qualifying events fall under the general category of lifestyle changes i.e.: marriage, divorce, loss of coverage, death, reduced work hours

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The undersigned hereby agrees to waive membership as an employee in the Utica University Health Insurance.

It is understood and accepted by the undersigned that he/she accepts the payment plan, regulations attached hereto, and that this plan is available only to those University employees whose spouse/domestic partner/parent possess comparable coverage with his/her employer, or if the University employee has access to comparable coverage through an alternate employer or organization membership, and that the payment is offered as an allowance for the purchase of supplemental medical insurance.

After the form has been properly executed, please return it to the Office of Human Resources or fax (315) 792-3386.

EMPLOYEE INFORMATION

_____ _____

Employee Name (Print or type) | Department

DEPENDENT INFORMATION

_____ _____

Spouse/Domestic Partner | DOB

_____ _____

Dependent Name | DOB

_____ _____

Dependent Name | DOB

_____ _____

Dependent Name | DOB

Reason for waiving coverage:

_____ Coverage through Spouse/Partner/Parent Employer

Employer Name: _____

Insurance Company: _____

_____ Other Reason (Explain): _____

_____ _____

Employee Signature | Date

ATTACH A COPY OF CURRENT INSURANCE CARD OR OTHER PROOF OF INSURANCE