Medical Buyout – Cash-In-Lieu of Health Insurance
Sworn Statement of
Alternative Health Insurance Coverage

Name:	**Social Security #**

The Colchester School 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 to the Plan Administrator.

***Enrollment in an "individually" purchased plan, through ACA/Vermont Health Connect is NOT an eligible alternative health insurance plan.**

Your Alternative Coverage Information:
Plan Under: ☐ Spouse/Partner ☐ Parent ☐ Medicare A ☐ Medicaid ☐ TRICARE ☐ Other Employer or Retirement
Plan Sponsor (Ex: Employer Name, Tricare, GMC etc.):
Insurance Company (Ex: BlueCross, Cigna, MVP etc.):
Effective for 12-Month Period Beginning:
My coverage under this plan is for (select one): ☐ Single ☐ Employee+Spouse ☐ Employee +Child(ren) ☐ Family

Your Tax Dependent(s) Coverage Information:

☐ I do not have any tax dependents or complete below.

	Spouse/Dependent Name	**Coverage Name**	**Effective Date**	**Does Not Have Comparable Coverage**
Spouse:				☐
Child:				☐
Child:				☐
Child:				☐
Child:				☐
Child:				☐

I certify that I am currently receiving comparable group health 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 "buy-out" if I do not supply information above for myself and, if applicable, my spouse and or tax dependents.*

**I understand that I will not receive the "buy-out" if I am covered by another VEHI BC/BS Health Care Plan provided by another VT public school.*

I understand that if my health insurance status changes during the Plan Year (Jan 1 – Dec 31, 2023), I must notify the Human Resources department at Colchester School District.

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:**

Please attach a copy of your insurance card