UTICA UNIVERSITY
HEALTH INSURANCE WAIVER BUYOUT PLAN 2023

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