Print Form

VERMONT

Department of Human Resources
Agency of Administration

Vermont Department of Labor

DECLARATION OF HEALTH CARE COVERAGE

This form must be completed annually by employees who are not enrolled in a Health Care plan offered by their employer, which provides both hospital and physician services.

Date_____

(Employer must retain this record for THREE years)

The purpose of this form is to obtain information regarding your health care coverage. The information certified on this form will be used solely for the purposes of determining if your employer must pay Health Care Contributions, as required by Act 191 of the 2006 Legislature, An Act Relating to Health Care Affordability for Vermonters.

Print Employees Full Name: _____

Employee ID or Social Security Number: _____

Employee: Please complete Section A or B, sign and date, and return form to your employer.

Section A: Complete this section **ONLY IF** you are eligible to enroll in the Health Care plan your employer offers, but have declined or refused such coverage. Please check the appropriate box.

- ☐ I do NOT have health care coverage that includes hospital and physician services.
- ☐ I have declined or refused the employer's plan because I have health care coverage that includes hospital and physician services.

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Section B: Complete this section if you are **NOT** eligible to enroll in the Health Care plan your employer offers. Please check the appropriate box.

- ☐ I do NOT have health care coverage **OR** I have coverage through VHAP or Medicaid.
- ☐ I am a **part-time** employee who generally works less than 30 hours per week **AND** I have health care coverage (other than VHAP or Medicaid) that includes hospital and physician services.
- ☐ I am a **seasonal** employee who expects to work for this employer 20 or fewer weeks during this calendar year **AND** I have health care coverage (other than VHAP or Medicaid) that includes hospital and physician services.

NOTE to Employee: If at some point within the next year your health care coverage changes; you are encouraged to complete another declaration.

By signature below, I certify the information contained in this form is the truth.

_____
Employee Signature

Date