UTICA UNIVERSITY
HEALTH INSURANCE WAIVER BUYOUT PLAN 2024

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