Cash-in-Lieu (Buyout) Payments

| | Casii-iii-Lieu (Buyout) Payiiieiits | | | | | |
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| employee if their alternative insurance coverage is an individual policy of health insurance, including individual policies on Vermont Health Connect.) Other permissible group health plan coverage: (a) another employer's group plan; however, employees will not be eligible for a CIL payment if the employee is simultaneously receiving health care benefits from the same or another school employer, (b) a spouse's health benefit plan (unless the spouse's health benefit plan is through another school employer), or (c) certain governmental plans, such as Medicare Part A, CHIP (Children's Health Insurance Program), Medicaid, & most TRICARE coverage for military veterans. Employees are required to certify that the employee, spouse, & any dependents eligible under the VEHI Health Plan are all enrolled in other permissible health plan coverage. FWSU requires employees provide proof of other permissible health plan coverage. PWSU requires employees provide proof of other permissible health plan coverage include member identification cards, a letter from an insurance company or health plan, a copy of enrollment must show the applicable coverage period. Employees who do not provide the required certification or required proof of alternative group health insurance by May 30th & November 30th will not be eligible to receive the CIL payment for the plan year. CIL Forfeiture Employees who do not provide the required certification or required proof of alternative group health insurance by May 30th & November 30th will not be eligible to receive the CIL payment for the plan year. CIL Forfeiture Employees who de not provide the required certification or flusurance Coverage I elect to waive health plan coverage and receive a Cash-in-Lieu payment. I have listed the other permissible health plan coverage in which my eligible family members (ax dependents, including spouse, if applicable) & I are enrolled. Family Your Families Names Health Insurance Plan Spouse/Parent's Employer Effective Dates (such as John Cougar) (such as | Employee Nan | ne: | | | | |
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| enrolled in other permissible health plan coverage. FWSU requires employees provide proof of other permissible health plan coverage. Proofs of enrollment in other health plan coverage include member identification cards, a letter from an insurance company or health plan, a copy of enrollment information, or a letter from another employer attesting to enrollment in that employer's health plan. All proof of enrollment must show the applicable coverage period. Employees who do not provide the required certification or required proof of alternative group health insurance by May 30 th & November 30 th will not be eligible to receive the CIL payment for the plan year. CIL Forfeiture Employees who receive a CIL Payment mid-year, and subsequently elect to join our health insurance plan at any point during that same plan/calendar year authorize FWSU to process a payroll deduction in the amount of the forfeited CIL prior to the effective insurance enrollment date. Signature Date Tax-Family Certificate / Certification of Insurance Coverage I elect to waive health plan coverage and receive a Cash-in-Lieu payment. I have listed the other permissible health plan coverage in which my eligible family members (tax dependents, including spouse, if applicable) & I are enrolled. Family Your Families Names Health Insurance Plan Spouse/Parent's Employer Effective Dates (such as John Cougar) (such as BCBS) (such as Milton Town SD) (such as 1/1-12/31/24) Employee Spouse Dependent Dependent Dependent | (a) anoth simult (b) a spou (c) certai | er employer's group pla aneously receiving health use's health benefit plan (u n governmental plans, sud | n; however, employees will care benefits from the same unless the spouse's health be th as Medicare Part A, CHIP | or another school employer, nefit plan is through another sc | chool employer), or | |
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| Dependent Dependent | Family Members Employee Spouse Dependent | ve health plan coverage a nich my eligible family mer Your Families Names | and receive a Cash-in-Lieu probers (tax dependents, incluing Health Insurance Plan | payment. I have listed the otleding spouse, if applicable) & I a Spouse/Parent's Employer | ner permissible health plan are enrolled. Effective Dates | |
| Dependent | - | | | | | |
| | | | | | | |
| 113 you have additional dependency predoctate the reverse side of this joint to effect the injointation requested abovery | - | tional denendents inlease use | the reverse side of this form to er | I Iter the information requested above | ».) | |
| I understand my eligibility to receive the CIL payment requires my family members (spouse and tax dependents) & I remain enrolled in other permissible group health plan coverage (that is not individual health insurance). I agree to notify Human Resources at hr@fwsu.org within 30 days if one or more of my family members or I lose the coverage identified above. Signature Date | I understand r enrolled in ot Resources at h | my eligibility to receive th her permissible group he | ne CIL payment requires my ealth plan coverage (that is | family members (spouse and to not individual health insurance members or I lose the coverage | ax dependents) & I <i>remain</i> e). I agree to notify Human | |

• Be sure to attach your proof of other permissible health insurance! (meaning a copy of your health insurance card)