Cash-in-Lieu (Buyout) Payments

Employee Name: _____

To be eligible for the CIL payment the employee, spouse, & all eligible family members who are tax dependents of the employee must be covered by other permissible group health plan coverage. (Federal tax law prohibits a CIL payment to employees 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.** 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 30th & November 30th 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 Members	Your Families Names (such as John Cougar)	Health Insurance Plan (such as BCBS)	Spouse/Parent's Employer (such as Milton Town SD)	Effective Dates (such as 1/1-12/31/24)
Employee				
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				

(If you have additional dependents, please use the reverse side of this form to enter 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** _____

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