PROOF OF OTHER COVERAGE STATEMENT

If you elect to **WAIVE MEDICAL COVERAGE**, to receive a cash allocation you must complete this form, provide proof of other coverage* and sign the statement below.

Name:_____

Last First MI

I attest to having minimum essential coverage (as defined the Internal Revenue Service) through another group health plan for myself, and coverage for all individuals that I reasonably expect to claim as a personal exemption deduction for the taxable year and for the 2019 plan year to be eligible to receive a cash payment. This proof of and attestation to coverage is required every plan year.

_____

Source of other coverage (i.e. employer name)

_____

Insurance company or the organization providing coverage

**Acceptable proof of other coverage examples includes a current medical card or a confirmation of enrollment letter from the medical plan or other employer*

Please check the box below:

☐ I certify that the above information is true and correct as of the date indicated below.

_____

Signature Date

Return the completed form to Human Resources as soon as possible. Thank you.

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HUMAN RESOURCES ONLY:

HIRE DATE: _____ ☐ **FULL-TIME** ☐ **PART-TIME** _____

CASH ALLOCATION AMOUNT: _____

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