THIS FORM MUST BE COMPLETED ANNUALLY BY ALL EMPLOYEES

Vermont Department of Labor

DECLARATION OF HEALTH CARE COVERAGE

Employer: This form is ONLY to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You are required to maintain these documents together in a file in the event of an audit (for a minimum of three years).

Employer's Legal Name: _____

Print Employee's Full Name: _____

Employee ID or Social Security Number: _____ DOB _____

EMPLOYEE TO COMPLETE: *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 under 21 V.S.A., Section 2003. Return to employer when complete.*

I AM OFFERED AND AM ELIGIBLE FOR HEALTH CARE COVERAGE BY MY EMPLOYER:

☐ I have elected to accept the health care coverage offered and provided by my employer.

I AM OFFERED AND AM ELIGIBLE FOR HEALTH CARE COVERAGE BY MY EMPLOYER BUT HAVE ELECTED NOT TO ACCEPT THE COVERAGE OFFERED (√ *appropriate box*):

☐ I have Health Care Coverage that includes hospital and physicians services from another source other than Medicaid or Vermont Health Benefit Exchange (VHBE): (Specify Below) _____	☐ I have no health care. ☐ I have Medicaid. ☐ I am a full time employee and have health care as an individual through the Vermont Health Benefit Exchange.

I AM NOT ELIGIBLE FOR HEALTH CARE COVERAGE OFFERED BY MY EMPLOYER: (√ *appropriate box*):

☐ I am a part-time employee who works less than 30 hours per week **AND** I have coverage from a source other than Medicaid that offers hospital and physicians services. ☐ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year **AND** I have coverage from a source other than Medicaid that offers hospital and physicians services. ☐ I have Health Care Coverage that includes hospital and physicians services: (Specify) _____ Employer Note: these individuals will need to be included in your uncovered hours, if you do not offer your plan to **ALL** of your full-time employees.	☐ I am a part-time or seasonal employee and I do not have health care coverage OR I am covered by Medicaid. ☐ I have no health care.

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

☐ I certify the above information is accurate and true to the best of my knowledge and belief.

_____ _____

Employee Signature Date

Employer – Retain this document on file for THREE YEARS