COMMUNITY COLLEGE OF VERMONT
VERMONT STATE UNIVERSITY

VERMONT
STATE COLLEGES SYSTEM

OFFICE OF THE CHANCELLOR
PO BOX 7
MONTPELIER, VT 05601
P (802) 224-3000

VSC Retiree Health Insurance Form

ENROLLMENT ON THE VSC HEALTH INSURANCE COVERAGE

Per terms of the Collective Bargaining Agreements or Personnel Handbook, VSC retirees are eligible to enroll on the VSC medical and dental insurance programs available to retirees. **Please select one of the following three options:**

☐ I wish to enroll (remain enrolled) in the VSC insurance program.
Please sign the form and return it by October 31st

☐ I wish to enroll (remain enrolled) in the VSC Opt-out program.
Please complete the waiver questionnaire below, sign the form and return it by October 31st

☐ I wish to waive enrollment on both the VSC health insurance and Opt-out programs.
Please complete the waiver questionnaire below, sign the form and return it by October 31st

WAIVER FORM FOR VSC MEDICAL AND DENTAL INSURANCE

As a retiree of the Vermont State Colleges, I wish to enroll in the VSC Opt-out Program. As a participant in this program, I understand the following information:

1) Beginning on ______________ I will waive my enrollment in the Vermont State Colleges

   ☐ **medical** ☐ **dental**

   Please check either medical only or both medical and dental boxes.

2) I have other medical and dental insurance coverage and therefore do not need the VSC health insurance coverage. (Proof of coverage must be attached.)

3) In return for waiving the medical and/or dental insurance coverage, I will receive a lump sum payment of

   - **$1,800 for both medical and dental** for the full calendar year or a pro-rated amount based on enrollment in the Opt-out program.

OR

   - **$1,400 for medical only** for the full calendar year or a pro-rated amount based on enrollment in the Opt-out program.

4) The lump sum payment will be made at the end of the calendar year in which I participate in the plan and the payment will be subject to payroll taxes.

5) If the terms of the alternate coverage are materially changed, my eligible dependents and I shall be eligible to re-enroll in the VSC insurance during the open enrollment period or under the IRS qualifying life event rules. In these circumstances, I will receive no payment from the VSC Opt-out program.

6) The VSC shall have the right to terminate or change the terms of the Opt-out plan at the end of each calendar year. If the terms of the Opt-out Plan are changed, I shall have the choice of continuing with the revised Opt-out plan or re-enrolling (including eligible dependents) in the VSC health insurance plan.

7) I may elect to participate in the Opt-out program effective on January 1 of any year. Once enrolled in the Opt-out program, I will not have the option of returning to full VSC health insurance coverage except under the conditions outlined above.

8) I agree to the terms and conditions above in conjunction with any applicable Personnel Handbook or collective bargaining Agreements and the VSC procedures for the "Opt-out" Program.

9) I am responsible for notifying the VSC of any changes in dependents or designated agents for notification purposes.

_______________________________ _______________________

Name (please print clearly) Institution

_______________________________ _______________________

Signature Date

If you have any questions, please contact us at (802) 224-3060, ext. 2 or by email at VSCBenefits@vsc.edu