

Chittenden Central Supervisory Union Cafeteria Plan

Cash-in-lieu of Insurance Election of Benefits Form

Name (Last, First MI)		Date
Social Security Number	Plan Year	
Election to receive Employer Contribution as Cash		
<p>I am eligible for the Employer contribution because I am not electing health insurance benefits, which I am eligible for. I select the following payment option below (please check one option):</p> <ul style="list-style-type: none"><input type="checkbox"/> I elect to receive the employer contribution as a single cash payment at the end of the Plan Year, on a date selected by my employer, to be taxed as regular income.<input type="checkbox"/> I elect to receive the employer contribution in two installments (mid Plan Year and at the end of the Plan Year), on dates to be selected by my employer, to be taxed as regular income. <p>I understand I cannot change my payment election during the Plan Year specified above.</p>		
<p>This agreement is subject to the terms of the Chittenden Central Supervisory Union Cafeteria Plan, as amended from time to time in effect, shall be governed and construed in accordance with applicable laws, shall take effect as a sealed instrument under applicable laws, and revokes any prior election relating to such plan.</p> <p>This election form is only valid for the Plan Year specified above. A new election must be made each Plan Year in which the employee wishes to participate.</p> <p>A <u>Sworn Statement of Alternative Health Insurance</u> and proof of alternative insurance must accompany this election form.</p>		
Employee's Signature:		Date:

Chittenden Central Supervisory Union Cafeteria Plan

Sworn Statement of Alternative Health Insurance Coverage

Name:	Social Security Number:
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The Chittenden Central Supervisory Union Cafeteria Plan requires that you enroll in the health insurance plan, unless you receive alternative medical insurance coverage. If you have alternative coverage, please complete the following, **attach proof of alternative coverageⁱ**, sign and return this form to Human Resources.

Alternative Coverage
Plan Sponsor:
Insurance Company:
Effective for the 12-Month Period Beginning (Plan Year effective date):

I certify that I am currently receiving comparable medical benefits as listed above. To the best of my knowledge this coverage is comparable to the health insurance provided by my employer. I understand that the Plan Administrator reserves the right to refuse this statement based on a finding that the alternative coverage is not comparable.

Under penalty of perjury, I declare that the information I have furnished above, to the best of my knowledge and belief, is true, correct and complete.

Employee's Signature:	Date:
Authorized Delegate of the Plan Administrator:	Date:

ⁱ Acceptable proof of alternative coverage shall include a copy of the employee's alternative medical insurance ID card indicating the employee's name as a dependent; a letter from the spouse/civil union partner's employer indicating the employee is covered under their plan; or, a letter from the alternative insurance carrier indicating proof of coverage.