Vermont Department of Labor

DECLARATION OF HEALTH CARE COVERAGE

EMPLOYER: This form is ONLY to be completed by employees if you offer and pay a portion of a health care plan that provides hospital and physician services AND… 1) the employee is eligible to enroll in such plan but elects not to; OR… 2) the employee can potentially be excluded from such reporting as they may meet the Health Care Contribution reporting definitions as a "part-time" or "seasonal" employee. **DO NOT RETURN THIS DOCUMENT TO THE VERMONT DEPARTMENT OF LABOR.**

Date _____

(Employer must retain this document for THREE years)

Employer's Legal Name: _____Vermont Hospitality Management_____

Print Employee's Full Name: _____

Employee ID or Social Security Number: _____

EMPLOYEE: Please complete Section A or B, sign and date, and return form to your employer.

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 by Act 191 of the 2006 Legislature, An Act Relating to Health Care Affordability for Vermonters.

Section A: Complete this section **ONLY IF** you are eligible to enroll in the Health Care plan your employer offers, but have declined or refused such coverage. Please check the appropriate box.

☐ I do NOT have health care coverage that includes hospital and physician services.

☐ I have declined or refused the employer's plan because I have health care coverage that includes hospital and physician services.

Section B: Complete this section if you are **NOT** eligible to enroll in the Health Care plan your employer offers.

☐ I do NOT have health care coverage **OR** I have coverage through VHAP or Medicaid.

☐ I am a **part-time** employee who generally works less than 30 hour per week **AND** I have health care coverage from a source other than VHAP or Medicaid that includes hospital and physician services.

☐ I am a **seasonal** employee who expects to work for this employer 20 or fewer weeks during this calendar year **AND** I have health care coverage from a source other than VHAP or Medicaid that includes hospital and physician services.

Section C: Complete this section if you are **electing** to enroll in the Health Care plan your employer offers.

☐ NECI Insurance (EE only) ☐ NECI Insurance (EE + dep)

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

By signature below, I certify the information contained in this form is the truth.

_____ _____

Signature Date

Employer - Retain this document in your records for THREE YEARS.