



UA Choice

Opt Out Form

www.alaska.edu/HR/benefits

Waiver of Coverage for FY08 Documentation of Other Coverage

- Open Enrollment
- New Hire
- Life Event: _____
Date of Life Event: _____

Employee ID	Campus	Work Phone
Last Name	First	M.

Please Print Legibly

New Hire: This form must be completed and received by your regional human resources office within 30 days of hire. A new form is required for each year you wish to opt-out of the UA Choice plan.

Life Event Change: This form must be completed and received within 30 days of the Life Event identified above.

_____ Name of Spouse/FIP through which other coverage is provided.	_____ SSN or Employee ID (use ID if UA employee)
<p>I hereby elect to waive health plan coverage under the UA Choice plan available to me as a University of Alaska employee. I understand that by making this legally binding election, the University of Alaska is excused from any obligation to provide health coverage to me and/or my dependents as a benefit of my university employment. I understand and agree that the University of Alaska is not liable for any losses or damages suffered by me and/or my dependents from this action.</p> <p>I agree to notify the University of Alaska within 30 days of loss of my other coverage.</p>	
_____ UA Employee Signature	_____ Date

To Be Completed by a benefits administrator or representative of the other health coverage company:

Coverage for the employee/spouse identified above is provided through:

_____ Employer's Name	_____ Employer's Phone Number
_____ Employer's Address	
_____ Health Coverage Company Name	_____ Policy/Plan Number
_____ Coverage Effective Date	_____ Coverage End Date (N/A if continuous)
_____ Signature of Benefits Administrator Or Insurance Agent	_____ Date

Return to Your Regional Human Resources Office

Please Note: Employees/Dependents who waive coverage are **NOT Eligible** for COBRA Coverage.

[Office Use Only: Entered By: _____ Date: _____ Effective: _____]