UA Choice
Opt Out Form
www.alaska.edu/benefits

Waiver of Coverage for FY14
Documentation of Other Coverage

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

Employee ID | Campus | Work Phone
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Last Name | First | M.

Please Print Legibly

This form must be completed and received by your regional human resources office by the following:
- Open Enrollment: 5 p.m., May 15, 2013.
- New Hire: Within 30 days of your hire date
- Life Event Change: This form must be completed and received within 30 days of the Life Event identified above.

The election to waive coverage remains in effect until you submit a UA Choice Enrollment Form at open enrollment or when you have a qualifying life event or loss of other coverage.

Name of Spouse/FIP

SSN or Employee ID (use ID if UA employee)

through which other coverage is provided.

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.

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

Employer or Plan Sponsor Name | Phone Number
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Employer or Plan Sponsor Address

Insurance Company Name | Policy/Plan Number
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I agree to notify the University of Alaska within 30 days of loss of my other coverage.

UA Employee Signature | Date
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Return to Your Regional Human Resources Office by 5 p.m. Wednesday, May 15, 2013

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

[ Office Use Only: Entered By: __________________________ Date: ______________ Effective: __________ ]