UNIVERSITY of ALASKA
Many Traditions One Alaska

UA Choice

Opt Out Form

www.alaska.edu/benefits

Waiver of Coverage for FY21
Documentation of Other Coverage

□ New Hire

□ Life Event:_____

Date of Life Event: _____

Employee ID	Campus	Work Phone
Last Name	First	M.

Please Print Legibly

This form must be completed and received by the Employee Transitions and Benefits team by the following:

- New Hire: Within 30 days of your hire date
- Life Event Change: 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 through which other coverage is provided.

SSN or Employee ID (use ID if UA employee)

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

Employer or Plan Sponsor Address

Insurance Company Name

Policy/Plan Number

I agree to notify the University of Alaska within 30 days of loss of my other coverage.

UA Employee Signature

Date

Please return this form to UA HR

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

Opt Out [349] [Office Use Only: Entered By: _____ Date: _____ Effective: _____

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