Ukpeagvik Iñupiat Corporation

SCA Health Benefits Waiver Form

Employee Name:	**Social Security Number:**
Subsidiary/Contract:	**Date of Hire:**

As a Service Contract Act ("SCA") employee, I understand that I will be automatically enrolled as **"Employee Only"** in the High Deductible Basic Plan under the UKPEAGVIK INUPIAT CORPORATION Group Health and Welfare Benefit Plan. I understand that I may waive my coverage only if I am currently covered under another employer-sponsored group health plan, VA coverage or TRICARE by submitting a completed Health Benefits Waiver Form along with proof of other coverage.

I hereby acknowledge that I elect to waive the "Employee Only" coverage under UIC's High Deductible Basic Plan due to my current coverage under another employer-sponsored group health plan, VA coverage or TRICARE. I agree to provide proof of this coverage by providing a copy of the front and back of my current medical insurance identification card, or a letter of certification. I understand that this request will not be processed until proof of coverage is received.

I understand that during the November 2020 open enrollment I will be able to submit as proof of coverage a copy of my 2019 insurance identification card. I understand that by submitting my 2019 plan information, I am certificating that coverage will remain in effect for the 2020 plan year. If requested by UIC, I will comply with providing copies of my 2020 insurance information.

I understand that this Health Benefits Waiver Form and proof of other coverage must be received in the Benefits office of UIC by the Open Enrollment deadline of **November 8, 2019**. I further understand that if I do not provide proof of other medical coverage within this time frame, I will not be given an opportunity to waive this coverage until a subsequent Open Enrollment period or upon the occurrence of a special enrollment event as described in the Summary Plan Description for the UKPEAGVIK INUPIAT CORPORATION Group Health and Welfare Benefit Plan. I understand that I must provide notice of a special enrollment event within the time frames described in that Summary or I will not be permitted to enroll myself, spouse or dependents.

By signing this form, I am aware that I am making a binding election for my health coverage for the Plan Year 2020.

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Employee Signature Date