Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547 Phone: (802) 828-2551

VT Form HC-2	DECLARATION OF HEALTH CARE COVERAGE	This form must be completed annually by all uncovered employees. Employers must retain this form for 3 years.

Employer: This form is **only** to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You must retain all employee declaration forms together in a file for three years and be able to produce them in the event of an audit.

Employer's Legal Name *(Please print)* _____

Employee: Complete and sign this form and return it to your employer. The purpose of this form is to obtain information regarding your health care coverage. The information you provide on this form will be used solely for purposes of determining if your employer must pay Health Care Contributions as required under Vermont law at 32 V.S.A § 10503.

Employee's Full Name *(Please print)*	
Employee ID or Social Security Number	**Date of Birth**

Will the employee be under the age of 18 for the entire calendar year? ☐ YES ☐ NO

If **YES**, stop. Please sign the bottom of the form and submit it to your employer.

If **NO**, please continue to complete this form and submit it to your employer.

Check the box beside the statement that best describes your health care coverage.

1. My employer offers health care coverage to me.

◯ I have accepted the health care coverage offered and provided by my employer.

2. My employer offers health care coverage to me, and I have <u>not</u> accepted my employer's coverage.

◯ I have health care coverage that includes hospital and physicians services from a source other than Medicaid or Vermont Health Benefit Exchange.

My coverage is provided through: _____

◯ I am a full-time employee and have health care coverage as an individual through the Vermont Health Benefit Exchange.

◯ I have Medicaid.

◯ I have no health care coverage.

3. My employer does <u>not</u> offer health care coverage to me.

◯ I am a part-time employee who works fewer than 30 hours per week, **<u>and</u>** I have coverage from a source other than Medicaid that offers hospital and physicians services.

◯ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year, **<u>and</u>** I have coverage from a source other than Medicaid that offers hospital and physicians services.

◯ I have health care coverage that offers hospital and physicians services.

My coverage is provided through: _____

◯ I am a part-time or seasonal employee, and I do not have health care coverage **<u>or</u>** I am covered by Medicaid.

◯ I have no health care coverage.

☐ **I certify the above information is accurate and true to best of my knowledge and belief.**

Employee Signature _____ Date _____

Note: If your health care coverage changes within the year, you must complete a new Declaration of Health Care Coverage.