

EVIDENCE OF COVERAGE CERTIFICATION

I, _____(employee's name) hereby affirm that:

- a. I elect to opt out of medical coverage offered to me by Allegheny College.
- b. I have medical coverage through a plan that is not sponsored by Allegheny College.
- c. I agree to notify Allegheny College if there is any change of coverage status within thirty (30) days of change in writing to the Office of Human Resources.
- d. I understand that any opt out benefit payment received will be treated as ordinary income.
- e. My coverage is through the following:

Insurance Company Name: _____

Group Number: _____

Policy Effective Date: _____

As proof of coverage, I have attached (please circle one of the following and attach to this certification):

- A. Letter from the insurance carrier,
- B. Letter from my spouse's employer,
- C. Copy of my insurance card.

I affirm that the assertions in this Certification are true to the best of my knowledge.

Signature of Employee

Date