Logan City School District

WAIVER OF INSURANCE COVERAGE

For Plan Year 2023 - 2024

I have been given the opportunity to enroll in the Logan City School District's health insurance benefit provided to all eligible employees. With this waiver, I hereby affirm that I and/or my dependents am/are currently enrolled in a benefit plan that provides minimum value (as determined under the Internal Revenue Service).

I understand that my dependents and I may not be eligible to enroll in the District's Health insurance plan until the next open enrollment period unless I have a change in family status, or my coverage terminates from my other provider(s); and that may also be subject to medical underwriting.

In general, a group health plan provides minimum value if it is designed to pay at least 60% of the total cost of medical services for a standard population. If you have a question about whether a particular group health plan provides minimum value, please contact the plan sponsor before signing below.

Logan City School District's EMPLOYEE NAME _____

I have coverage available from the following carrier(s):

HEALTH INSURANCE COVERAGE		
PROVIDER	**CONTRACT/GROUP NO.**	**EFFECTIVE DATE**
INDICATE TYPE OF INSURANCE COVERAGE	❑ Single ❑ Two Party ❑ Family	
NAME OF PERSON CARRYING INSURANCE		

I elect to have my district contribution deposited into an:

❑ **HRA** (Pelion Benefits)

❑ **HSA** (Motiv HSA) By checking this option I certify that I am covered under a qualifying high deductible health plan as defined by IRS (Internal Revenue Service).

I understand that I and/or my dependents may not be eligible to enroll in Logan City School District's health insurance benefit until the next open enrollment period or unless I have a change in family status, my coverage terminates from my other provider(s) which may also be subject to medical underwriting.

Signature of Logan City School District Employee:

_____ _____

Printed Name Employee Signature