EMERY COUNTY SCHOOL DISTRICT
HEALTH INSURANCE WAIVER FORM

Name:_____

Address:_____

Phone #:_____

Position:_____

Work Location:_____

By signing below, I voluntarily elect to waive my health insurance coverage offered by Emery County School District.

I understand that in order to waive my health insurance coverage offered by Emery County School District, I must provide evidence of other health care insurance coverage.

I understand that in return, I will receive a monthly stipend according to the rules of Policy GCBD-R/GDBD-R.

I also understand the conditions under which I can revoke this election and reinstate my health insurance coverage.

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Employee Signature:_____ Date:_____

For District Office

Proof of Other Coverage Received on:_____ Company:_____

Monthly Stipend Amount:_____ Month Stipend Begins:_____

Date Heath Insurance Terminates:_____