

Lorain City Schools

Waiver of Insurance Coverage — Full Time LEA Employees Only

2601 Pole Avenue
Lorain, Ohio 44052
Phone: 440-830-4052
Fax: 440-233-2228

Members may elect to “opt-out” of the Board-provided major medical insurance coverage. A member who elects to opt-out shall be compensated as follows:

1. A bargaining unit member who can show proof of other insurance coverage may elect not to participate in coverage as offered by the Board. The member shall be compensated in the amount of **\$335** for opting out of single coverage and **\$500** for opting out of family coverage, less appropriate taxes, per month for which month he/she did not have coverage.
2. Bargaining unit members may elect to “opt-out” of Board-provided coverage during an approved open-enrollment period, within thirty (30) days of eligibility for benefit coverage and/or within thirty (30) days from a qualifying event change (i.e., marriage, loss of coverage from the other source).
3. A bargaining unit member whose spouse is also a Lorain Schools employee, and is eligible for group health benefits as provided by the Board, is not eligible to participate in the “opt-out” program and shall not be eligible to participate in the “opt-out” program and shall not be eligible for any “opt-out” payments.
4. Members may elect to opt-out of the insurance program during the annual enrollment period for the succeeding calendar year.

If you choose to waive your health insurance coverage (medical/prescription drugs) for the plan year, submit this form with proof of other insurance (and dependent information (birth certificates) if electing family coverage) to the Treasurer’s Office within 30 days from your hire date or within 30 days of a qualifying event. The plan year runs from July 1, through June 30.

Waiver Selection

I am eligible for the following coverage under the health insurance plan of the district and am **“opting-out”** of coverage –

☐ Single coverage

☐ Family Coverage

I understand that by checking either box above, I am choosing not to be covered under the health coverage designated by the Board, and any later request for enrollment and acceptance will be subject to all underwriting requirements. If you are declining enrollment for yourself or yourself and dependents (including your spouse) because of other coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you will be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the qualifying life event.

This waiver is for the 2026-2027 plan year.

Payment will be made the second pay of the month.

Employee Name (Print)

Employee Signature

Date

Administrator Name (Print)

Administrator Signature

Date

THIS OPT OUT FORM ALONG WITH ALL REQUIRED DOCUMENTATION IS DUE TO THE TREASURER’S OFFICE BY JULY 30th.