

Full Name: _____

I am continuing in the same coverage that I currently have: (Initial)_____

I am electing the following coverage:

Managed Dental Care Plan	Semi-Monthly Rate (10/1/2023)
EE (Employee Only) _____	$12.21
EE/SP (Employee/Spouse) _____	$24.43
EE/Child (Employee/Child(ren)	$31.99
Family _____	$41.89

PPO Plan	Semi-Monthly Rate (10/1/2023)
EE (Employee Only) _____	$23.97
EE/SP (Employee/Spouse) _____	$48.67
EE/Child (Employee/Child(ren)	$65.87
Family _____	$97.00

Employee Signature: _____ **Date:** _____

Waiver Only Section

I am waiving dental coverage for this plan year and understand I cannot enroll until the next open enrollment, unless I have a qualifying event.

Employee Signature: _____ **Date:** _____

Print Name: _____