I am electing the following coverage:

Managed Dental Care Plan	Semi-Monthly Rate (10/1/2024)
EE (Employee Only) _____	$11.68
EE/SP (Employee/Spouse) _____	$23.37
EE/Child (Employee/Child(ren)	$30.61
Family _____	$40.08

PPO Plan	Semi-Monthly Rate (10/1/2024)
EE (Employee Only) _____	$22.94
EE/SP (Employee/Spouse) _____	$46.57
EE/Child (Employee/Child(ren)	$63.03
Family _____	$92.83

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

Employee Signature:_____ **Date:** _____

Print Name:_____

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: _____