2019 Benefit Election Form

Dental Coverage: Please indicate below whether you are declining or electing dental coverage. If you are electing coverage, please check the appropriate coverage-tier box matching the plan & coverage you're electing for the 01/01/2019-12/31/2019 plan year.

Please note that if you are making changes to your current coverage such as adding/removing dependents, or you wish to join the plan for the first time, you will need to contact HR immediately for further instruction.

Employee Name (Print) ____

Dental Coverage

❑ **DECLINE: I decline dental coverage effective 1/1/2019 for the 2019 plan year.**

I understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan if I experience a qualifying event. This is provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of a marriage, birth or adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days of the event.

❑ **ELECT: I choose the following dental coverage type & premium deduction:**

BENEFITS	Metlife Dental PPO	
Deductible (Single/Family)	$50/$150	
Annual Maximum per Covered Person	$1,000	
Preventative Services	100%	100% of Allowed Amount
Basic Services	80%	80% of Allowed Amount
Major Services	50%	50% of Allowed Amount
Orthodontia (up to age 19)	50%	50% of Allowed Amount
Orthodontia Lifetime maximum	$1,000	

*This illustration is a highlight of benefits & should not be relied upon to fully determine your coverage. Please refer to the Certificate of Coverage, Riders and/or Amendments for final confirmation of coverage.

***Please select the plan you're electing & check the box for the appropriate level of coverage & rate.**

PER PAY CONTRIBUTIONS		Metlife Dental PPO
Single		$13.43
Two Party		$26.45
Family		$38.92

Your signature below authorizes the indicated deductions to be taken from your pay on a pre-tax basis. If you do not want your premium deducted on a pre-tax basis, notify HR immediately for further instruction.

Employee Signature ________________________________ **Date** ____________________