MATAWAN ABERDEEN REGIONAL SCHOOL DISTRICT

DENTAL COVERAGE SALARY REDUCTION AGREEMENT 2022-2023

DELTA DENTAL PREMIER PLAN BUY UP

☐ I am currently enrolled in the Delta Dental PPO Plan and would like to ***BUY UP*** to the Premier Plan. ☐ I am currently enrolled in the Delta Premier Plan and would like to ***KEEP*** it. ☐ I would like to ***ENROLL*** in the Delta Dental Premier Plan.	Cost to Buy Up 10 Month Employees $9.59 per pay	Cost to Buy Up 12 Month Employees $7.99 per pay

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

HOME ADDRESS _____ CITY _____ STATE_____ZIP _____

SSN _____ DOB _____ DATE OF HIRE:_____

AGREEMENT

I have elected to increase my dental coverage, as selected above, at my own cost above the single coverage cost provided by the Board of Education. I understand that I have the right to allow the Company to reduce my compensation on a pretax basis during the plan year (or the part of it that remains) and to apply this reduced amount toward the cost of the option(s) that I have elected. I also understand that my cost of the plan will be deducted over the term of my contract (i.e. 10 month employee or a 12 month employee). I further understand that if the cost of my elected option(s) changes from time to time, my share of the cost, and the amount by which my compensation is reduced, may be automatically adjusted accordingly.

I acknowledge that this agreement is irrevocable unless there is a change in status. A change in status includes, but is not limited to, the following events: marriage; divorce or legal separation; death of a spouse or dependent; birth or adoption of a child; a change in the number of my dependents; a termination or commencement of employment; a strike or lockout; commencement of or return from an unpaid leave of absence; a change of worksite; a change in my or my spouse's employment status that affects eligibility for participation in this or another cafeteria plan; a change in my residence or in the residence of my spouse or dependents; or my dependent either satisfying or ceasing to satisfy eligibility requirements for a coverage due to attainment of an age, a change in student status or similar circumstances.

By signing below, I hereby authorize the Company to adjust my compensation based on the benefit option(s) that I have elected. I further understand that the benefit option(s) that I have elected and this Agreement will remain in force throughout the plan year (or the part of it that remains), unless there is a change in status, as described above.

EMPLOYEE SIGNATURE _____ **DATE** _____