MONADNOCK DEVELOPMENTAL SERVICES

DENTAL COVERAGE – Full Time Employees

Employee: _____ Effective Date: January 1, 2023 – December 31, 2023

Please enroll me in MDSs agency sponsored plan. I authorized MDS to deduct my share of the cost through payroll deductions on a biweekly basis. I understand that the benefit options I have elected will remain in force, unless I notify Human Resources, **in writing**, that I have had a change in family status within 30 days of such change.

☐ I elect to have my biweekly deduction on a pre-tax basis. I understand that my social security wages and taxes will be reduced by my wage reduction under the Premium Offset Plan (POP), which may reduce my social security or disability benefits. I understand that I cannot change or revoke this agreement unless I have a change in family status as defined by the IRS.

☐ I DO NOT elect to participate in the POP. I understand that my biweekly deduction will be taken as an after tax deduction.

	Bi Weekly	Annual	Please indicate your premium cost here.
Single	$2.30	$59.80	
Two Person	$4.48	$116.48	
Family	$7.64	$198.64	

Employee Signature: _____ Date: _____

Processed _____Date:_____