Newton Board of Education
Waiver of Dental Benefits

Employee's name:_____
Printed

I hereby certify that I am waiving the district's dental plan.

This waiver is in effect for the period July 1, 2024 through August 31, 2025.

In return, the Board has agreed to reimburse me at the stated contractual amount, prorated each paycheck of the period for which I have opted out, subject to all appropriate deductions. This payment is not to be considered a salary payment and, as such, is not pensionable. I understand that I am responsible for any additional tax liabilities on this money.

I further certify that I understand and agree that my waiver of the foregoing benefits is of my own volition. It is not based upon representations from either the Newton Board of Education other than the aforementioned monetary reimbursement. I agree to hold both the Board and the Association harmless with regard to any adverse results of my voluntary and informed waiver of the foregoing benefits.

I understand that I may revoke this waiver prior to the expiration date shown above only under the following hardship/change of life circumstances:

- Termination of employment of person with benefits
- Legal Separation (copy of decree required)
- Group contract/policy terminated of person with benefits (proof of termination required)
- Disability of spouse which eliminates benefits (proof of termination of benefits required)
- Divorce (copy of decree is required)
  Death of Spouse (copy of death certificate required)

Should I revoke the foregoing waiver prior to the end of the year for which I initially opted out, I understand that the reimbursement to which I am entitled shall be pro-rated based upon the period of time I am not covered by the district's benefit plan(s). I further understand that I may restore the benefits for which I am eligible during the next open enrollment period. Such benefits would commence on July 1st of the next academic year.

Signed:_____
Employee

Date:_____

Verifier:_____
Carrie Docherty, Benefits Coordinator
(Upon obtaining proof of other coverage)

Date:_____

Designee verification of other
health benefit coverage:

Name of Insured:_____
ID #_____
Company:_____