



**Norton City Schools
CERTIFIED STAFF
DENTAL INSURANCE WAIVER**

20 _____ - 20 _____ school year

I, _____, hereby waive my rights and elect not to be covered under the District's dental plan.

10.07 INSURANCE OPTION

- A. Regular full-time employees who elect prior to the first day of the school year to not participate in Article 10.01 who were employed on September 1st of any year and who are not covered on the District's plan, on written request to the Treasurer, will receive a stipend in lieu of insurance coverage of One Thousand Dollars (\$1,000.00) to be paid on or before August 31st of any year in which the employee did not have coverage. An additional stipend in the amount of Fifty Dollars (\$50.00) will be paid to employees if they don't select dental coverage.

Pursuant to IRS Letter Ruling 9406002, I understand this stipend will be subject to Federal, State and City taxes but will not be reportable income for retirement purposes towards my final average salary.

STAFF SIGNATURE _____ DATE: _____

WITNESS SIGNATURE: _____

**** Return to Treasurer's Office****