



Group number: _____

Requested Effective Date: _____/_____/_____

Waiver of Dental Benefits and Notice of Special Enrollment Rights

Instructions: Please complete boxes outlined in **RED**.

Please complete the following:

Employer Name: _____

Employee Name:

Last Name: _____ Middle Initial: _____ First Name: _____

Social Security Number: _____

For the plan year effective: ____/____/____

I am waiving coverage for (check all that apply):

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependent(s)- Please list names: _____

The reason for declining coverage (check all that apply):

☐ Covered by spouse's group coverage

☐ Enrolled in other Insurance (name of company and plan): _____

☐ Medicare/Medicaid/VA

☐ Other (Please explain): _____

☐ No coverage

Acknowledgement and Signature

I hereby certify I have been given the opportunity for the available group dental benefits offered by my employer. The benefits have been explained to me, and I and/or my dependent(s) have declined to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or dental carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Signature of Employee: **X** _____

Signature Date: ____/____/____