Metro Atlanta Financial Group

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 overage (check all that apply):

- ◯ Covered by spouse's group coverage
- ◯ Enrolled in other Insurance (name of company and plan):

_____

- ◯ Enrolled in Individual coverage
- ◯ 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 this 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: ___/___/_____