

DENTAL

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made during the annual open enrollment period unless I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

I have been offered coverage by my employer, but at this time I wish to decline dental coverage for:

- Myself and my dependents Spouse/Partner Child(ren)

Reason

Required only if employee waiving coverage — not required if waiving coverage for dependents only

- Other Group Coverage Carrier Name _____ Group # _____
 Medicare/Medicaid provided dental coverage
 Individual Policy
 Other Reason _____ (explanation required)

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be subject to civil fines and/or penalties.

Signature of Enrollee _____ Date _____