

Waiver of Group Coverage

Company Name: _____

Employee Name: _____ Date of Birth: _____

Please Check One:

- I waive my employer's group **dental** insurance coverage for myself and my dependents (if any).
- I am enrolling in my employer's group **dental** insurance coverage but I am waiving coverage for my dependents.

Reason for Waiving Coverage – Please Check One:

- Covered through spouse's employer

Employer Name: _____

Insurance Company: _____

- Other reason (explain): _____

As a result, I waive my and/or my dependents' (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future only: within 30 days of involuntary loss of other group coverage; or, at the time of my employer's annual open enrollment.

Employee Signature: _____ Date: _____