Waiver of Coverage: Please sign and date this form where indicated below.

Please Use Ink or Type | GROUP ID:

E. Dependent and Other Insurance Information (Complete ONLY for Dental Enrollment)

List Dependents to be Covered for Dental Benefits (if applicable)

	Last Name	First Name	MI	Sex	Birth Date
EMPLOYEE:					
SPOUSE:					
CHILDREN:					

Are you or any of your eligible dependents covered by any other dental plan? ☐ Yes ☐ No If YES, please list:

Name of Insured	Insurance Company Name & Phone Number	Employer

Is coverage through other dental plan? ☐ Single ☐ Family

F. WAIVER OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)

The group program has been offered to me, and after carefully considering its benefits, I have decided:

(Please indicate your choice)
- ☐ (a) not to enroll myself or dependents in the Program
- ☐ (b) not to enroll my dependents in the Program

I understand that if I desire to participate in the Program at some future date, my coverage or my dependents' coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand if a physical examination or further medical information is required, it will be at my own expense.

Employee Signature _____ Date Signed _____

Note: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.