



Fax: 650.240.2231

DECLINATION / WAIVER FORM
Use for Delta Dental Programs

Employee Name _____	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Social Security Number _____
Company Name _____	Policy # _____	

I have been notified of my eligibility for enrollment in my employer's Delta Dental benefit program. However, I voluntarily decline to enroll myself and my eligible dependents (if any).

I have also been notified that if I waive coverage for my eligible dependents who do not have other group coverage, they will **never** be allowed re-entry into the program. I had been informed that Delta Dental does not have an open enrollment.

I acknowledge that if I and/or my eligible dependents lose coverage under another employer group dental program, I must request of my employer that I and/or my eligible dependents be enrolled in my employer's Delta Dental benefit program. A written request must be made no later than 30 days after the termination of coverage.

DENTAL COVERAGE DECLINED FOR: (Check all that apply)

- Myself
- Spouse*
- Child(ren)

* Spouse includes domestic partner only if your employer offers this coverage.

Reason for declining coverage: (Check one)

- Covered by spouse's group dental coverage:
Carrier Name _____ and ID / Group Number: _____
- Covered by Individual dental coverage
- Other Reason: _____

Employee Signature

Date
