copower

Dental Waiver/Declination Form

Please fill out completely and submit to CoPower via fax at 650.348.1149 or email at requests@copower.com.

Member Information	
Member Name:	Member Social Security Number:
Employer Name:	CoPower ID#:

I have been notified that I am eligible for enrollment in my employer's dental benefit plan. However, I voluntarily decline/waive the right to enroll myself.

Reason for Waiving Coverage

☐ Covered by other dental coverage

Carrier Name: ________________________ ID/Group Number: __________________________

Declining Coverage

☐ I do not have other dental coverage and decline to enroll

I acknowledge that I will be unable to enroll at a later date unless I show proof of loss of coverage under another dental plan or the group plan contract allows me to enroll during the company's open enrollment period (if applicable). In the event that I do lose coverage under another plan, I understand I must enroll with my employer's dental plan on the first day of the month after loss of coverage.

Signature	
Member Signature:	Date:
Employer Signature:	Date: