

DECLINATION OF DENTAL COVERAGE

Employer name	
Name of employee declining coverage	
Employee's social security number	

I have been notified that I am eligible for enrollment in my employer's Delta Dental benefit plan. However, I voluntarily decline to enroll myself and any eligible dependents.

I acknowledge that I will be unable to enroll at a later date unless I show proof of loss of coverage under another employer dental plan. In the event that I do lose coverage under another employer plan, I must enroll with Delta on the first day of the month after loss of coverage.

Name of the other employer dental benefit plan: _____

Signature of employee _____ Date _____

Signature of employer _____ Date _____