

## DECLINATION OF DENTAL COVERAGE

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

**Eligible employees may refuse dental coverage only if they are currently covered by another employer dental plan (i.e., a spouse's plan).**

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. By signing below, I certify that the reason I am declining enrollment in the Delta Dental benefit plan is that I am now covered under another employer dental plan.

I acknowledge that if I lose coverage under the other employer dental plan, I must request of my employer that I be enrolled in my employer's Delta Dental benefit plan. This request must be made within 30 days after termination of my coverage under the other employer dental benefit plan.

Name of the other employer dental benefit plan: \_\_\_\_\_

Signature of employee \_\_\_\_\_ Date \_\_\_\_\_

Signature of employer \_\_\_\_\_ Date \_\_\_\_\_