

## 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.** And if I do lose coverage under another employer plan, I must enroll on the first day of the month after loss of coverage or within 30 days after loss of coverage, whichever is earlier.

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

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

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