CBA Blue

An independent licensee of the Blue Cross and Blue Shield Association.

LAMOILLE NORTH SUPERVISORY UNION

WAIVER OF DENTAL COVERAGE

Employee's Name: _____

Please check the appropriate answers.

I choose to decline enrolling myself and/or my eligible dependent(s) in the group insurance plan(s) indicated below. (Please indicate your waiver of coverage by checking all applicable categories and selected family members.)

- ☐ Exclude myself
- ☐ Exclude my spouse
- ☐ Exclude my child(ren)

Reasons For Declining Coverage:

- ☐ Covered by spouse's plan
- ☐ Covered by other insurance
- ☐ Covered by H.M.O.
- ☐ Other (Explain) _____

I acknowledge that my employer has explained the coverage(s) available. I have been given the opportunity to enroll in my employer's group medical plan for the coverage(s) and have elected not to enroll myself and/or my dependents, if any. I understand that I will not be able to enroll in the Plan until the next open enrollment period.

Employee's Signature _____ Date _____

SIGN ONLY IF COVERAGE IS BEING WAIVED

Rev. 10/24/18