Delta Dental of Massachusetts

Waiver of Group Coverage

Company Name: ____

Employee Name: ____

☐ I waive my employer's group dental insurance coverage for myself and my dependents (if any).

Reason for Waiving Coverage — Please Select One:

☐ Covered through spouse's employer

Employer Name: __________________________________

☐ Other reason (please explain):

As a result, I waive my and/or my dependents (if any) eligibility to enroll in my employer's group plan at this time. I understand that I and/or my dependents may enroll under this plan in the future only under the following circumstances:

- within 30 days of involuntarily loss of other group coverage; or
- at the time of my employer's annual open enrollment period.

Employee Signature: ___________________________ Date: _________

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