DENTAL PLAN WAIVER

NAME:_____

EMPLOYEE IDENTIFICATION NUMBER: _____

DEPARTMENT:_____

This waiver is to be completed by employees who do not wish to enroll in coverage through the University of Dayton's Group Dental Plan with Superior Dental Care, or by employees who are currently enrolled but wish to cancel their coverage.

The dental plan options offered by the University of Dayton have been explained to me. After serious consideration, I have decided not to take advantage of this coverage.

I understand that **I will not** be eligible to enroll in dental coverage until the next annual open enrollment period which normally takes place during the month of October with coverage effective January 1st. Enrollment **will be permitted** upon loss of other health insurance coverage if the Office of Human Resources is contacted within thirty (30) days of the occurrence. A letter from the insurance company or employer stating the coverage termination date is required. Enrollment may also be permitted in the case of additional qualifying events as outlined in the Benefit and Leave of Absence Handbooks located on the HR website at www.udayton.edu/~hr/. Proof of the occurrence of one of these events is required.

SIGNATURE_____DATE_____