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Waiver of Delta Dental Coverage Form

Company Name: _____

Employee Name: _____ Date of Birth: _____

Reasons for Waiving Dental Benefits (check one):

____ Covered through parent's Dental plan

____ Covered through spouse's employer's Dental plan

Employer name _____

Dental Carrier _____

Must provide copy of dental I.D. card
or copy of coverage certificate

____ Other _____

Signature of the Employee

Date

This form may
be duplicated