Northeast Delta Dental
One Delta Drive
P.O. Box 2002
Concord, NH 03302-2002
603-223-1000
800-537-1715

PLEASE PRINT IN BLUE OR BLACK INK

Waiver of Dental Coverage

I, _____
Name

certify that I am an employee of _____
Company Name

and I am eligible for the employer sponsored dental plan with this company. I am waiving my right to group dental coverage for myself and my dependent(s), if any.

☐ **I am covered under another dental program through:**

☐ **spouse**

☐ **other** _____
Explain

Name of dental carrier:_____

☐ **I do not have dental coverage.**

I understand that once I have waived this dental benefit, subsequent enrollment in the dental plan would only be permitted during the next annual open enrollment period, or for a qualifying event.

Employee Signature: _____**Date:**_____

Employer Signature: _____**Date:**_____