# Waiver of Group Dental Benefits

Employee Name

Job Title

Employee Number (ID, Social Security, etc.)

For the plan year effective I am waiving coverage for:

☐ Myself

☐ Spouse/Domestic Partner

☐ Dependents(s):

If selecting Dependent(s), please list their name(s):

I am waiving coverage due to:

☐ My preference not to have coverage

☐ Coverage under my spouse's/domestic partner's plan

☐ Other coverage

This other coverage is:

☐ Employer-sponsored Group Plan ☐ Individual policy ☐Medicare ☐ COBRA ☐TRICARE ☐ Medicaid

**Special Enrollment Notice and Certification** – *Please review and sign below if you wish to waive coverage*

By signing below,

- I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any.
- I am declining enrollment as indicated above. I understand that I cannot enroll in coverage until the next open enrollment period unless I experience a change-in status event.
- If I experience a change-in status event, I understand that I must request enrollment no more than 30 days after the event. If I do not do so, I will not be able to enroll until the next open enrollment period. I understand that in order to request special enrollment or obtain more information, I should contact my group administrator.
- I understand that the individual mandate was effective January 1, 2014 and that most individuals are required to have health insurance or pay a tax. It is my responsibility to seek professional tax advice when making the decision to waive coverage. The Diocese of Erie is not responsible for any taxes that I may incur.

Employee Signature Date