

## **Dental Waiver Form**

I acknowledge that ALTRES has offered me a group dental plan and that I am declining dental coverage for myself and my dependants at this time.

I understand that by choosing not to enroll now that I will be unable to enroll myself and/or my dependants until the next annual open enrollment period or the occurrence of a qualifying event.

Print Name		
Signature		
 Date	· · · · · · · · · · · · · · · · · · ·	