School Year: _____

TRENTON PUBLIC SCHOOLS

DENTAL BENEFIT OPT-OUT FORM

Employee Name: _____ Social Security No.: _____

Contact Phone Number: _____ Date of Hire: _____

☐ I decline to enroll in my employer's dental coverage for the reason shown below:

- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in another insurance carrier plan
- ☐ Other: _____

I acknowledge I have been given the opportunity to apply for dental coverage. However, I have elected not to enroll. By declining dental coverage, I acknowledge that I and my dependent(s) (if any) have to wait until the plan's next annual enrollment to enroll for coverage, unless there is a qualifying event.

_____ _____

Employee Signature Date