LifeMap Assurance Company™
100 SW Market Street
P.O. Box 1271, MS E-3A
Portland, OR 97207-1271
(503) 721-7161 (800) 794-5390

DENTAL WAIVER FORM

POLICYHOLDER INFORMATION	
Employer Name/Policyholder Name	Group Policy #

EMPLOYEE INFORMATION		
Employee First Name / MI / Last Name		
Street Address / City / State / Zip		
Social Security Number	Date of Birth (MM/DD/YYYY)	Date of Hire (MM/DD/YYYY)
Average Work Week Hours	Waiving coverage for: ☐ Employee ☐ Employee/Dependent(s) ☐ Dependent(s) Only	

WAIVING COVERAGE INFORMATION

I have been offered dental coverage under my Employer's plan through LifeMap Assurance Company (LifeMap), but I am waiving coverage for the following reason(s). **Check all that apply:**

☐ I do not wish to enroll myself and/or my dependent(s) in my Employer's dental plan at this time.

☐ I currently have dental coverage elsewhere:

Carrier_____ **Policy Number**_____

Policy Type: ☐ Group ☐ Individual ☐ Medicare ☐ Medicaid ☐ TriCare ☐ Indian Health Service
☐ Government sponsored dental plan ☐ Other_____

If you have checked the above for coverage elsewhere, please attach evidence of coverage. Evidence may be a copy of the previous month's billing, insurance ID card, or a current EOB (Explanation of Benefits).

If you are waiving coverage under this dental plan for yourself and/or your dependent(s) because of other dental insurance, you may under certain circumstances be able to enroll yourself or your dependent(s) under this plan in the future, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you waive enrollment under this dental plan at this time, and later acquire a new dependent due to marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s) under this plan, provided that you request enrollment within 30 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. However, if you voluntarily end your other coverage after waiving this coverage, you and your dependent(s) may not be eligible to enroll in this plan until the next annual enrollment period. Please contact your Group Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under my Employer's dental plan through LifeMap until the next annual enrollment period, unless I and/or my dependents(s) qualify for a special enrollment period.

I further certify that all information completed on this form is true, correct and complete and acknowledge that my coverage is subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

▶ _____ _____

Employee Signature **Date**