



## DECLINATION OF DENTAL COVERAGE

I hereby acknowledge that I have been offered group dental coverage under my employer's ODS dental plan for myself and/or my dependents. However, I am declining coverage for:

(check one)

- Myself (employee only coverage)
- My eligible family members (spouse and/or dependent children)
- Myself and my eligible family members (employee and dependent coverage)

I decline ODS coverage for myself and/or my family members due to the following reason:

(check one)

- Group coverage through my spouse's employer
- Premium contribution
- Other (specify reason) \_\_\_\_\_

### Late Enrollee

I understand that if I do not enroll myself and/or my eligible dependents within 31 days of first becoming eligible, I may do so later as a "late enrollee". I understand that as a late enrollee, I am only eligible to enroll during my employer's annual open enrollment period. Special Enrollment rights are explained below.

### Special Enrollment

I further understand that if I am declining enrollment for myself and/or my dependent(s) (including my spouse) because of other dental coverage, I may in the future be able to enroll myself or my dependent(s) in this plan provided that I request enrollment within 31 days after my other coverage ends. If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. In addition, if I or a dependent lose coverage under Medicaid or CHIP **OR** become eligible for premium assistance for Medicaid or CHIP, I may be able to enroll myself and the dependent, provided that I request enrollment within 60 days after the termination of coverage or the determination of eligibility for premium assistance.

Coverage for either enrollment circumstances will begin at my employer's first premium payment date following application.

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Employee signature

Date

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Employee name (print)

Employer Name (print)

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