Delta Dental Plan
of Massachusetts

Waiver of Coverage Form

Company Name: _____

Employee Name: _____ Date of Birth: _____

Reasons for Waiving Coverage (check one):

____ Covered through parent's Dental plan

____ Covered through spouse's employer's Dental plan

Employer name _____

Dental Carrier _____

Must provide copy of dental I.D. card
or copy of coverage certificate

_____ Other _____

_____

_____

Signature of the Employee Date

This form may