DENTAL PLAN REFUSAL FOR EMPLOYEES IN C.U.P.E.

Name: ________________________________ Employee ID # ________________________
(please print)

Please check one of the following:

☐ I do not wish to join the Dental Plan. I understand that by refusing to join the plan when first eligible, I will not be able to join the Plan in the future.

or

☐ I do not wish to join the Dental Plan at present as I am currently covered under another Dental Plan. If I should lose this coverage I may apply to join the SFU Dental Plan.

Dental Plan:

Group# ________________ Identification # ______________________________

Name of Carrier ____

PLEASE NOTE:
You are required to complete this form or the Dental Plan portion of the Application for Group Benefits form prior to the last day of the fifth (5th) month of continuous employment in a continuing position.

________________________________ ________________________
Signature Date

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