



Rayant Insurance Company of New York
Rayant Insurance Company of Pennsylvania

SMALL EMPLOYER DENTAL
BENEFITS WAIVER OF COVERAGE

Group Policy No.:
Policyholder Name:
Employee Name: Social Security #:
Marital Status: Single Married Widowed Divorced
Date of Employment: Date of Birth:

I was given the opportunity to enroll in this plan of group dental benefits offered by my employer and insured by Rayant. I refuse the following:

- Employee, Spouse, and Child(ren) coverage
Spouse coverage
Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

- other fully-insured Group Dental Plan sponsored by this employer
other Group Dental Plan sponsored by my spouse's employer
other group coverage sponsored by another organization
covered under Medicare
other reasons (please explain)

Please identify Group Dental Plan(s) and provide names(s) of Policyholder(s), carrier(s) and policy number(s).

Policyholder/Name:
Carrier: Policy number:
Policyholder/Name:
Carrier: Policy number:
Policyholder/Name:
Carrier: Policy number:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other Group Dental Plan coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

If the reason for the refusal of coverage is coverage under another Group Dental Plan, it is important to provide information concerning that Group Dental Plan on this Waiver of Coverage form. If you fail to provide this information on this Waiver of Coverage form and you later become ineligible for such other coverage and then wish to enroll in any of the refused coverages, you will be considered a Late Enrollee and may be subject to the pre-existing conditions exclusion.

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form and coverage may be subject to a pre-existing conditions exclusion.

Signature of Employee

Date

Signature of Witness

Date