MetLife

Dental Waiver Form

Employee Name: _____

Employment Date: _____

I have been offered coverage under the Columbia Falls School District Dental Insurance Plan through MetLife Insurance. I am waiving coverage for the following reason(s).
Check all that apply:

☐ I do not wish to enroll myself and/or my dependents in the Columbia Falls School District Dental Insurance Plan at this time.

☐ I and/or my dependents currently have medical coverage elsewhere.

I understand that I and/or my dependents will be unable to obtain coverage under the Columbia Falls School District Dental Insurance Plan except during a special enrollment period, or during the designated annual enrollment period.

_____

Signature of Employee

_____

Date