

Refusal of Employee and/or Dependent Coverage

PacifiCare[®]
Dental & Vision Administrators

Attn: Employer Groups, MAS, LC05-232
PacifiCare Dental and Vision Administrators
P.O. Box 25187
Santa Ana, CA 92799-5187
Phone (714) 513-6494
or 1-800-622-6388, option #4

Employee Name: _____

Group Name: _____ Group Number: _____

I have been given an opportunity to apply for Group Dental/Vision coverage with PacifiCare Dental and Vision Administrators, and I have declined to apply for the following coverage(s) provided under this plan:

Dental

- Self
 Dependents

Vision

- Self
 Dependents

The reason(s) for declining this/these coverage(s) are:

- Covered through Spouse
 Do not wish to participate
 Other: _____

Name of current dental/vision coverage
carrier & group # if waiving due to other coverage: _____

I understand that if I desire to apply for coverage for myself and/or my dependents at a later date, I will have to wait until the group open enrollment, and that there will be no coverage or benefits until my application has been accepted by PacifiCare Dental and Vision Administrators and a *Certificate of Insurance* or *Evidence of Coverage and Disclosure Form* booklet has been issued to me.

Date

Employee Signature

Social Security Number