



# OFFICE OF PENSIONS

## DENTAL INSURANCE COVERAGE

**REFUSAL**

I elect not to participate in a dental insurance coverage plan offered through the Office of Pensions.

Name: \_\_\_\_\_

Employee ID: \_\_\_\_\_

Signature: \_\_\_\_\_

Social Security # \_\_\_\_\_

Date: \_\_\_\_\_

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.