



SIMON FRASER UNIVERSITY
ENGAGING THE WORLD

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