



Dental Waiver Form

This waiver form is to be used by students who have been enrolled in their student organization's dental plan administered by Gallivan & Associates Student Networks (G&A), but wish to waive the coverage for such plan because he/she currently has comparable coverage elsewhere. **Please complete this form and submit it along with confirmation of existing coverage** to the Benefits Plan Office. The waiver form along with confirmation of coverage specific to dental must be received by the **DEADLINE DATE ESTABLISHED BY THE STUDENT ORGANIZATION. NO EXCEPTIONS ARE MADE.**

New January Registrants: Full-Time or Part-Time students may waive the student dental plan for the January term. The waiver form must be submitted by the deadline date established by the student organization.

PLEASE NOTE: For the student's convenience, after the initial waiver form is processed, the dental benefits are automatically waived each year. Your waiver information will remain in force until an opt in request is made through your Student Benefits Plan Office (regardless of a change in your student status, ie: Undergraduate to Graduate, or taking a year off and returning). Please contact the

Student Benefits Plan Office to confirm your eligibility and/or opt out status prior to the applicable deadline. If you lose the comparable coverage used to waive the dental plan, you must notify the Student Service Co-ordinator within **30 days** to be covered by the Student Dental Plan. Proof of loss of coverage is also required on re-application for coverage.

INCOMPLETE WAIVER FORMS INCLUDING THOSE SUBMITTED OR FAXED WITHOUT CONFIRMATION OF EXISTING COVERAGE WILL NOT BE PROCESSED.

Confirmation of existing coverage must show the name of the insurance company providing coverage and the policy number. The easiest way for you to provide confirmation of coverage is by presenting a copy of a benefits card or a confirmation letter from the employer/insurance company. Confirmation may also be provided by presenting other documents such as a recent statement of claim, web page print-out or other insurance company document identifying you, the insurer and the policy number.

Once we confirm coverage, we DO NOT retain any confirmation documentation that you provide to us.

STUDENT INFORMATION

_____ Last Name _____ First Name _____ Initial _____ Gender

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 Date of Birth

_____ Mailing Address _____ City/Province _____ Postal Code

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 Student ID Number

EXISTING COVERAGE INFORMATION

I have existing dental coverage and wish to use that coverage to waive the Student Dental Plan coverage.

Yes No

_____ Insurer's Name _____ Policy No.

PLEASE READ THE FOLLOWING BEFORE SIGNING THIS FORM:

I wish to decline the student dental plan coverage. Comparable dental coverage is presently provided for me under another insurance plan. I acknowledge that as a result of this waiver, I forfeit all rights to coverage otherwise available to me under the student dental plan. I realize that I will not be able to rejoin the plan until I enrol next year or unless I cease to be covered by my existing plan and apply within **30 days**. I **MUST** come into the Student Benefits Plan Office to reinstate coverage. I understand that I would have been able to claim under my existing insurance as well as under the student dental plan, thereby increasing my coverage.

I understand that the information provided above is required in order for me to waive the dental coverage. I hereby authorize and consent to the use, release and exchange of the above information between the educational institution, the student organization, Gallivan & Associates, third party service providers and the insurance carrier(s) to be used solely in connection with the administration of the Student Dental Plan. I confirm that all the information provided by me herein is accurate. I understand that it is solely my responsibility to ensure that the Student Benefits Plan Office has received and approved my waiver application.

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 Student Signature _____ Phone

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 Date

YOU MUST SUBMIT THIS WAIVER PRIOR TO 4:00 p.m. ON THE ASSIGNED DEADLINE DATE

Waiver forms will not be returned. After it has been signed by the Student Benefits Plan Office, please make a copy for your records prior to submitting. If you fax in the waiver form, it is the student's responsibility to retain a copy of the fax transmission report.

OFFICE USE ONLY

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 Processing Date _____ Processed By



The Integrated Care Solution