CoPower ***ONE***™

CoPower *ONE* Waiver/Declination Form

Waiver/Declination of Coverage

Please fill out completely and send to CoPower via fax at 650.348.1149 or email at requests@copower.com.

Member Information	
Member Name:	Member Social Security Number:
Employer Name:	CoPower ID#:

I have been notified that I am eligible for enrollment in my employer's CoPower ***ONE*** plan, which has a dental component. However, I voluntarily waive/decline to enroll myself in the plan due to the following reason:

Reason for Waiving Coverage

☐ Covered by another dental plan:

Carrier Name: ___________________________ ID/Group Number: ___________________________

Declining Coverage

☐ I do not have other dental coverage and decline to enroll.

I acknowledge that by signing this form, I am waiving my enrollment in dental, vision and life coverages. I will be unable to enroll at a later date unless I show proof of loss of coverage under another dental plan. In the event that I do lose coverage under another dental plan, I must enroll with CoPower ***ONE*** plan on the first day of the month after loss of coverage.

Signature	
Member Signature:	Date:
Employer Signature:	Date: