I, ____________________________, (please print) wish to drop Delta Dental coverage for the following people enrolled on my plan:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________
5. ______________________________________
6. ______________________________________
7. ______________________________________
8. ______________________________________

_________________________________________  _________________
Employee Signature  Date

*Please note that termination of coverage due to a qualifying event (not during open enrollment) requires that coverage is continued through the month in which the termination is requested (for example, if a request to terminate coverage is made on December 5th because there was a divorce, coverage continues through December 31st and is cancelled effective January 1)*