



## HUMAN RESOURCES

• Insurance Benefits •

### Acknowledgement of Dental Participation Requirement

I acknowledge that I have read and understand the dental participation requirement:

*“Effective January 1, 2012, there is a two year enrollment commitment. I will not be allowed to cancel coverage until I have been on the plan for two years. If I do cancel coverage, I will not be allowed to re-enroll for two years.”*

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Last 4 digits of SS#/Employee ID #**