

**Mount Allison University  
Opt-Out Form for Dental Plan**

I, \_\_\_\_\_ (please print), hereby elect to opt out of the dental plan available through my employment with Mount Allison University. I declare that I currently have comparable coverage under another supplementary dental plan, as identified below. I understand that had I not opted out of the dental plan, I would have been able to claim under both my current plan and the Mount Allison dental plan to increase my coverage. I also agree to notify the Human Resources Department in writing within thirty-one (31) days of any change to my coverage status under my current dental plan.

Details of Existing Dental Coverage

Name of Insurance Company: \_\_\_\_\_

Group Policy Number: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date