Delta Dental of Arizona

5656 W. Talavi Blvd.
Glendale, AZ 85306
Phone (602) 938-3131 / Toll Free (800) 352-6132
Fax (602) 588-3921

Employee Coverage Waiver Form

To be completed by employees not enrolling with Delta Dental

EMPLOYEE INFORMATION

Marital Status ☐ Single ☐ Married Gender ☐ M ☐ F Date of Birth ______/______/______ Date of Hire ______/______/______

Last Name	First	Middle Initial	Home Telephone

Home Address (Mailing)	City	State	Zip Code

I certify that I am covered by another insurance carrier: YES ☐ NO ☐

If yes, please fill out the information requested below:

OTHER DENTAL COVERAGE INFORMATION

Policy holder Name	Employer	Relationship to Employee	Insurance Carrier	Effective Date of Coverage

AUTHORIZATION

By signing below, I certify that all information contained herein is complete and accurate to the best of my knowledge.

Employee's Signature / Authorization ______________________ Date ______________________