Renaissance SM

Waiver Form

I hereby certify that I understand that I am eligible for the dental program administered by Renaissance Life and Health Insurance Company of America. I decline to participate in this program.

Signature _____

Name of Employer _____ Date _____

If Renaissance Life and Health coverage is waived because of coverage through another source:

Name of Other Dental Carrier _____

Subscriber's Name _____

Subscriber's Social Security Number _____

D-003-1 ENGLISH (06/06)

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