

## AFFIDAVIT OF OTHER DENTAL INSURANCE COVERAGE

I, \_\_\_\_\_, hereby state and attest to the following:  
(Please Print)

I am declining coverage under the Caltech Student Dental Insurance Plan for myself and any of my eligible dependents because I/we are currently covered under another dental plan.

I understand that by declining the Caltech Student Dental Insurance Plan at this time, I may **not** enroll at a later time unless I can show proof of loss of other dental coverage (through a parent, spouse, private insurance, or other) within 31 days from the date of loss. If I/we do not enroll in the Caltech Student Dental Plan within 31 days of loss, I/we can enroll during the Student Dental Open Enrollment Period every September.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

**Please return to the Benefits Department 161-84 by October 7, 2005. If this form is not received by October 7th you will be defaulted into the Delta Dental HMO Plan effective October 1, 2005.**