



LOS ANGELES POLICE RELIEF ASSOCIATION, INC.

600 N. GRAND AVENUE, LOS ANGELES, CA 90012-2212 • (213) 674-3701 • (888) 252-7721 • FAX (213) 674-3715 • www.lapra.org

DENTAL DECLINATION FORM

Dental Coverage Offered By the Los Angeles Police Relief Association, Inc.

CIGNA PPO (Dental)
CIGNA Net (Pre-Paid Dental)

I hereby decline dental coverage offered by the Los Angeles Police Relief Association, Inc. for the following persons:

Fill out a statement for each individual eligible for coverage, but for whom you are declining coverage.

Self: _____ SSN: _____

Check Reasons:

- I am covered under another dental plan
- I am not covered under another dental plan, but do not choose to enroll at this time

Spouse/Domestic Partner Name: _____ SSN: _____

Check Reason:

- I am covered under another dental plan
- I am not covered under another dental plan, but do not choose to enroll at this time
- I am legally divorced from this person

Child: _____ SSN: _____

Check Reason:

- I am covered under another dental plan.
- I am not covered under another dental plan, but do not choose to enroll at this time.
- This dependent is not a full time student and/or is over age 25.

Child: _____ SSN: _____

Check Reason:

- I am covered under another dental plan
- I am not covered under another dental plan, but do not choose to enroll at this time
- This dependent is not a full time student and/or is over age 25.



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Child:	SSN:
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Child:	SSN:
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Check Reason:

- I am covered under another dental plan
- I am not covered under another dental plan, but do not choose to enroll at this time
- This dependent is not a full time student and/or is over age 25.

Child:	SSN:
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Check Reason:

- I am covered under another dental plan
- I am not covered under another dental plan, but do not choose to enroll at this time
- This dependent is not a full time student and/or is over age 25.

I, the undersigned, understand that by declining coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage for a period of up to 12 months.

“Note: If you are declining coverage for yourself or your dependents (including your spouse) because of other dental insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption you may be able to enroll yourself and your dependents, provided within 30 days after marriage, birth, adoption or placement for adoption.

For LAPRA Use Only		
Member Name (Print or Type)	Dental Plan	Received & Recorded by
Member Signature	Date:	Date