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Santa Barbara County Employees' Retirement System

WAIVER OF DENTAL BENEFITS

Name: _____ Social Security # _____

Effective Date of Waiver _____

1. AWARENESS OF RIGHT

I, _____, am aware of my right, pursuant to the class action entitled George Bobolia et al. v. County of Santa Barbara et al. (Santa Barbara Superior Court Case No. 153464), to participate in my Plan-Sponsored dental program.

2. RIGHT ONCE WAIVED IS WAIVED FOREVER

I am further aware that, if I waive my right to participate in a Plan-Sponsored dental program, I am forever precluded from reinstating my right to participate in such dental programs.

3. WAIVER

I hereby declare that on the effective date shown above, my participation in the Plan-Sponsored dental program shall be terminated and I forever waive my right to be reinstated in any Plan-Sponsored dental program. I understand that upon the effective date of the termination of my participation in the dental plan, I will no longer be responsible for any future premium costs for that dental benefit.

Signature of Retiree or Beneficiary

Date