PUBLIC EMPLOYEES SUPERVISORS' DENTAL PROGRAM

VOLUNTARY WITHDRAWAL FORM

I voluntarily withdraw from the Public Employees Supervisors' Union Dental Program effective _____.

I understand my signature forfeits all rights to enroll in the program for a period of **five (5) years.**

Print name _____

Signature _____ date_____

Please print the following information:

Home Address _____
_____
_____

Phone Number (home)_____(work)_____

Program Administrator Completes:
Name _____phone _____
Effective date of Removal from Program _____