

U. S. Restaurants, Inc. Dental Plan

**VOULUNTARY CANCELLATION OF EMPLOYEE
CONTRIBUTIONS FOR DENTAL COVERAGE**

(Please Print)

NAME: _____

HOME ADDRESS: _____

SOCIAL SECURITY #: _____

UNIT #: _____

To The Human Resources Department:

I hereby provide notification that I refuse to make contributions for my dental coverage through my employer's Section 125 Premium Plan. I understand all coverage for myself, and any covered family members, will cease as soon as practicable, after your receipt of this form. I also understand, according to IRS regulations, I will not be permitted to re-enroll in the plan for the remainder of the plan policy period.

Signature of Employee

Date

Authorized Representative

Date Authorized