DENTAL COVERAGE OPT-OUT FORM

Plan Year: 2025

WAIVER OF PARTICIPATION

The OMNIVISION Employee Benefit Program has been explained to me and I decline to participate in the dental plan at this time. I understand that if I waive coverage now, I must wait until the next Plan Year/Open Enrollment Period to enroll unless I experience a qualifying life event as defined by OMNIVISION's Plan.

I further understand that this does not affect my continued participation in the Company's 401(k) plan or voluntary programs (as I choose to enroll in) and other benefit plans such as holidays, vacation, life insurance, and worker's compensation program.

OVT Employee Name:	
OVT Employee Signature:	
Date:	

By entering my name, I acknowledge that I read and understood the above regarding waiving my dental coverage.

OPT-OUT ELECTION

I choose to waive participation in the dental coverage offered through the OMNIVISION Employee Benefit Program. For the declination of dental coverage offered under the OMNIVISION Employee Benefit Program, I elect to receive a cash payment in the form of taxable income under OMNIVISION in the amount of $35 for each month in which my waiver of participation remains in effect.

Name of Employer/Organization providing other Group Coverage (if any, or "N/A")	
Insurance Carrier (if any, or "N/A")	
Name of Insurance Holder (if any, or "N/A")	
OVT Employee Name:	
OVT Employee Signature:	
Date:	

By entering my name, I acknowledge that I read and understood the above regarding my Opt-Out election.