Application for Individual and Family Dental Policy/ Change of Status Form

TruAssure Insurance Company is an Illinois domiciled Company.

ATTENTION: TruAssure Enrollment | PHONE: (888) 559-0781

Please type or print in black ink. Please complete the application in its entirety. An incomplete application could result in either a decline of application or delay in effective date.

APPLICANT/MEMBER/PARTICIPANT INFORMATION

Note: If the member is a child, the application must be signed by a parent/legal guardian/responsible party. Please complete this section for the member.

Last Name	First Name	Middle Initial	Date of Birth ___/___/_____

Mailing Address	City	State	ZIP

Phone Number ( )	E-Mail Address	Social Security Number (optional)	Gender ☐ Male ☐ Female

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Civil Union ☐ Domestic Partnership

I consent to receive Explanation of Benefits (EOBs) from TruAssure by e-mail. ☐ Yes ☐ No

I consent to receive policy and legally required communications from TruAssure by e-mail. ☐ Yes ☐ No

Are you and/or your dependent(s) covered by any other dental benefit program? ☐ Yes ☐ No
If Yes, name of carrier _____

FLORIDA, OKLAHOMA, PENNSYLVANIA and VIRGINIA residents must answer the following question. If the response is yes, you must complete the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance and submit with this application. You must also retain one for your records.

Do you plan to replace any of your existing dental insurance with this policy? ☐ Yes ☐ No

REASON FOR APPLICATION

☐ Initial Application ☐ Change of Dependent(s) ☐ Change in Coverage Type ☐ Policy Re-enrollment

REQUESTED EFFECTIVE DATE

___/___/_____ **Paper applications must be received by the 20th of the month to be effective the 1st of the following month.**

In Missouri only, TruAssure will notify you as to whether or not the application has been accepted or give you the reason for any further delay within sixty (60) days that TruAssure received the application in our home office.

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DENTAL BENEFIT PLAN SELECTION AND CORRESPONDING MONTHLY PREMIUM RATES

Note: Please complete the Monthly Premium Rates section that is applicable to the dental benefit plan you selected.

SELECT DENTAL BENEFIT PLAN

Select only one dental plan and where applicable, the desired annual maximum.

☐ **TruAssure Individual and Family Max Savings Plan**

☐ **TruAssure Individual and Family Choice Plan* with the following annual maximum:**

☐ Annual Maximum $1,250 ☐ Annual Maximum $2,000 ☐ Annual Maximum $3,000

*TruAssure Individual and Family Choice Plan not available in Ohio.

☐ **TruAssure Individual and Family Choice Plus Plan* with the following annual maximum:**

☐ Annual Maximum $1,250 ☐ Annual Maximum $2,500 ☐ Annual Maximum $5,000

*TruAssure Individual and Family Choice Plus Plan not available in Ohio.

☐ **TruAssure Basic Adult or Child Dental Plan, ACA Certified**

☐ **TruAssure Preferred Adult or Child Dental Plan, ACA Certified***

MONTHLY PREMIUM RATES FOR TRUASSURE INDIVIDUAL AND FAMILY MAX SAVINGS PLAN, CHOICE PLAN OR CHOICE PLUS PLAN

Indicate the applicable rate below for the selected Dental Plan.

Member Only $	Member Only (Child Only) $	Member + 1 Dependent $	Family (Member + 2 Dependents) $

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MONTHLY PREMIUM RATES FOR TRUASSURE INDIVIDUAL AND FAMILY BASIC ADULT OR CHILD PLAN, ACA CERTIFIED OR PREFERRED ADULT OR CHILD PLAN, ACA CERTIFIED

Indicate the applicable rate below for the selected Dental Plan.

Members Age 18 and Under (Rate per member)	**Members Age 19 and Over** (Rate per member)
$	**$**

Please list all persons to be covered under the policy.

Add	Delete	First Name	Last Name (If different from Applicant)	Date of Birth MM/DD/YYYY	Relationship to Applicant	Dependent Status	Gender
				___/___/_____		☐ Military ☐ Disabled	☐ Male ☐ Female
				___/___/_____		☐ Military ☐ Disabled	☐ Male ☐ Female
				___/___/_____		☐ Military ☐ Disabled	☐ Male ☐ Female
				___/___/_____		☐ Military ☐ Disabled	☐ Male ☐ Female
				___/___/_____		☐ Military ☐ Disabled	☐ Male ☐ Female

CHANGE OF COVERAGE

THIS SECTION IS ONLY APPLICABLE FOR CURRENT MEMBERS WITH COVERAGE CHANGES.
Please check all events that apply.

☐ **Add Dependent due to:**

☐ Birth ☐ Adoption/Placement for Adoption ☐ Marriage ☐ Domestic Partnership

☐ Civil Union ☐ Legal Guardianship ☐ Administrative or Court Order

☐ Dependent Child with Disability ☐ Military Dependent ☐ Other _____

List Names of new Dependent(s) above.

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OTHER CHANGES

☐ **Drop Dependent (list below) due to:**

☐ Age ☐ Death ☐ Other Coverage Elsewhere Name of Dependent _____

☐ Age ☐ Death ☐ Other Coverage Elsewhere Name of Dependent _____

☐ **Name Change**

Former Name _____ New Name _____

☐ **Address Change**

Former Mailing Address	City	State	ZIP
New Mailing Address	City	State	ZIP

☐ **Change in Coverage Type** _____

PAYMENT INSTRUCTIONS

Choose your payment method: ☐ Bank Account ☐ Credit Card | **Payment options:** ☐ Monthly ☐ Annually

If your method of payment is bank account, all premiums must be paid electronically using your checking/ savings account. If your method of payment is credit card, all premiums are to be paid by credit card. Premiums will be drawn or charged on or about the 27th day of the month. Your initial premium will be deducted at the time your application is processed.

Please note: Paper applications must be received by the 20th of the month to be effective the 1st of the following month.

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR PAYMENT BY BANK ACCOUNT:

Name of Financial Institution

Financial Institution's City	**Financial Institution's State**	**Financial Institution's ZIP**

Type of Account (Choose one)

☐ Checking ☐ Savings Name on Account _____

Bank Routing Number	**Bank Account Number**

CONTINUED ON NEXT PAGE

PAYMENT INSTRUCTIONS (CONT'D)

PLEASE COMPLETE THE FOLLOWING INFORMATION FOR PAYMENT BY CREDIT CARD:

Card Type

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Name on Card	Card Number	Expiration Date ____ month ____ year	Security Code

Billing Address of the Cardholder if different from the address of the applicant

Address	City	State	ZIP

Authorization

By signing below (signature page is page 10 of this application), I hereby authorize TruAssure Insurance Company to deduct the premium amount stated above from the listed bank account or credit card on or about the 27th of each month for my monthly premium payment (if the payment method selected is monthly). I understand that the initial ACH debit or credit card charge to my account will occur immediately and if I have selected an annual payment option, the initial ACH debit or credit card charge will reflect the annual premium.

I agree that this authorization will remain in full force and effect until TruAssure has received written notification from me that I am terminating it. I agree to notify TruAssure in writing of any changes to my account information or termination of this authorization at least three (3) days (for ACH debits) or twenty-five (25) days (for credit card charges) prior to the next billing date.

I understand that TruAssure will notify me in advance of any changes to the premium amount. By signing below, I hereby authorize TruAssure and the bank or credit card company identified above to process the ACH debits or credit card charges authorized here. If I am not the insured person under this policy, I confirm that I am agreeing to pay this insurance premium on behalf of the insured person. Unless the insured person is a minor for whom I am a parent or legal guardian, I understand that any changes to the policy that may affect the charge amount will be communicated to the insured person only.

I agree that if I have any problems or questions regarding this authorization or my insurance policy, I will contact TruAssure for assistance at 888-559-0781. I guarantee that I am the account holder or authorized user for this bank account (for ACH debits) or legal card holder or authorized user (for credit card charges) and that I am legally authorized to enter into this Recurring ACH Debit/Credit Card Billing Authorization Agreement with TruAssure.

Additional Information if paying by ACH debit

If my financial institution rejects an ACH debit from TruAssure due to insufficient funds, I understand and agree that TruAssure may attempt to process the charge again within thirty (30) days if I have not provided an alternate payment method.

CONTINUED ON NEXT PAGE

FOR INDIVIDUALS IN ALL STATES BUT KANSAS: I understand that if my bank dishonors any ACH debit requested by TruAssure under this agreement, TruAssure may assess me a $25 service charge, and TruAssure may collect that service charge by means of an ACH debit.

FOR INDIVIDUALS IN KANSAS: I understand that if my bank dishonors any ACH debit requested by TruAssure under this agreement, subsequent payment of any premium due will not keep the Policy in force, except as provided in the Grace Period. If any premium due is not received by TruAssure before or at the end of the Grace Period, the Policy will automatically terminate at the end of the period for which the last premium was paid.

Additional Information if paying with credit card

FOR INDIVIDUALS IN ALL STATES BUT KANSAS: I understand that any transaction that is dishonored by my credit card company intended for payment to TruAssure may be assessed a $25 service charge by TruAssure. Further, I authorize TruAssure to make any charges on a future policy I may purchase from TruAssure on the same credit card if I give verbal consent to TruAssure.

FOR INDIVIDUALS IN KANSAS: I understand that if my credit card company dishonors any transaction requested by TruAssure under this agreement, subsequent payment of any premium due will not keep the Policy in force, except as provided in the Grace Period. If any premium due is not received by TruAssure before or at the end of the Grace Period, the Policy will automatically terminate at the end of the period for which the last premium was paid. Further, I authorize TruAssure to make any charges on a future policy I may purchase from TruAssure on the same credit card if I give verbal consent to TruAssure.

In making this application to TruAssure Insurance Company ("TruAssure"), for the dental coverage policy, I agree and understand that this application will become part of the Policy, and I agree to be bound by the terms of the Policy issued by TruAssure. I understand that, if applicable, my electronic signature on this form operates as my original signature. I further agree that the coverage requested is subject to the approval of TruAssure and that no agent or representative has authority to make changes or modify this application for coverage. I hereby represent that all of the information contained in this application is true and correct to the best of my knowledge. I further understand that any intentional omission or material misrepresentation of submitted data may cause this application and subsequent Policy to be null and void.

Please Note: Paper applications must be received by the 20th of the month to be effective the 1st of the following month. Paper applications received after the 20th will be effective the 1st of the month after the next month. If the application is created and submitted through the TruAssure.com web portal, the application will be processed the next business day and will be effective the 1st of the following month. Coverage is contingent upon underwriting acceptance.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

CONTINUED ON NEXT PAGE

PLEASE READ AND AGREE TO THE PRECEDING WARNING OR THE WARNING APPLICABLE TO YOUR STATE AND SIGN ON PAGE 10 OF THIS APPLICATION.

THESE STATES REQUIRE THAT WE ADVISE YOU OF THE FOLLOWING:

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CALIFORNIA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

CALIFORNIA: This policy does not offer pediatric Essential Health Benefits (EHB) as mandated under the Affordable Care Act.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits in false information materially related to a claim was provided by the applicant.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

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KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

THE COMMONWEALTH OF KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE per title 24-A Section 2186 (3): It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NORTH CAROLINA: Any person who knowingly and with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which "MAY" subject the person to criminal and civil penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with any intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

THE COMMONWEALTH OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TENNESSEE: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

THE COMMONWEALTH OF VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

THE COMMONWEALTH OF VIRGINIA: In the event of dispute, the provisions of the approved English version of the form will control.

THE COMMONWEALTH OF VIRGINIA: DESCARGO DE RESPONSABILIDAD: En caso de haber alguna disputa, prevalecerán las disposiciones de la versión en inglés aprobada del documento.

WASHINGTON: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WEST VIRGINIA: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DISCLAIMER: The Spanish version of this form is provided only as a courtesy to the customer. The English version of this form will be the presiding version in any case of a dispute or complaint.

DESCARGO DE RESPONSABILIDAD: La versión en español de este documento se proporciona únicamente como cortesía para el cliente. La versión en inglés de este documento constituirá la versión predominante en el caso de alguna disputa o reclamación.

TruAssure Insurance Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender, or gender identity.

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THE POLICY PROVIDES DENTAL BENEFITS ONLY. REVIEW YOUR POLICY CAREFULLY.

Applicant Signature	**Date** ___/___/_____

IF APPLICATION IS FOR A CHILD-ONLY POLICY, PLEASE COMPLETE THE INFORMATION BELOW.

Parent/Legal Guardian/Responsible Party First and Last Name		**Phone Number** ( )	
Mailing Address	**City**	**State**	**ZIP**
Email	**Relationship to Applicant**		

I certify that I am the parent or legal guardian of the child applicant and that I have the legal right to enter into this contract on their behalf.

Parent/Legal Guardian/Responsible Party Signature	**Date** ___/___/_____

AGENT/PRODUCER SECTION

In California only, Agent Attestation: (1) To the best of my knowledge, the information on the application is complete and accurate. (2) I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

I willfully state as true any material fact I know to be false, that in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).

Licensed Insurance Agent Signature (if applicable)	**Date** ___/___/_____
Printed Name of Licensed Insurance Agent (if applicable)	**Agent License Number or National Producer Number**
State of Agent License	**Agent E-Mail Address**
Licensed Insurance General Agent Signature (if applicable)	**Date** ___/___/_____
Printed Name of Licensed Insurance General Agent (if applicable)	**General Agent License Number or National Producer Number**
State of General Agent License	**General Agent E-Mail Address**

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Arabic
العربية
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-559-0779.

Chinese
繁體中文
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-559-0779。

French
Français
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-559-0779.

French Creole
Kreyòl Ayisyen
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-888-559-0779.

German
Deutsch
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-559-0779.

Gujarati
ગુજરાતી
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-888-559-0779.

Hindi
हिंदी
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-888-559-0779 पर कॉल करें।

Italian
Italiano
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-559-0779.

Japanese
日本語
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-559-0779 まで、お電話にてご連絡ください。

Korean
한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-559-0779 번으로 전화해 주십시오.

Portuguese
Português
ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-888-559-0779.

Russian
Русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-559-0779.

Spanish
Español
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-559-0779.

Tagalog
Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-559-0779.

Vietnamese
Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-559-0779.