



ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

Please print or type all answers.

FOR GROUP DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY COVERAGE

1. EMPLOYEE

Employee Name (First/Middle/Last)			Date of Hire (mm/dd/yyyy)
Date of Birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Single <input type="checkbox"/> Widowed
Home Address (Street, City, State, County, Zip Code)		Home Phone Number	E-mail Address
I consent to receive any communications from TruAssure by e-mail. <input type="checkbox"/> Yes <input type="checkbox"/> No			
I consent to receive policy related e-mails from TruAssure by e-mail. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Employer		Group Number	Effective Date of Coverage

2. EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES

Please check one of the options below:
 Yes, I want to enroll in this Group Coverage
 No, I do not want to enroll in this Group Coverage. *If "No", do you have other dental insurance coverage?* Yes No

3. REASONS FOR SUBMITTING THIS FORM

Initial or Open Enrollment COBRA COBRA End Date ____/____/____ Retiree
 Reinstatement due to: Rehire Loss of Other Coverage Other _____
 Add Dependent (list below) due to:
 Birth Adoption Marriage Domestic Partnership Loss of Other Coverage Legal Guardianship
 Disabled Dependent Military Dependent Other _____
 Date of Qualifying Event ____/____/____
 Drop Dependent (list below) due to:
 Age Death Divorce Other Coverage Elsewhere Date of Qualifying Event ____/____/____
 Termination of Employment Date ____/____/____ Covered Under Spouse Date ____/____/____
 Name Change (Former Name _____) Address Change

4. DEPENDENTS: (Indicate the names of all dependents to be insured under the Group Policy.)

ADD	DELETE	NAME	DATE OF BIRTH	ADD	DELETE	NAME	DATE OF BIRTH
<input type="checkbox"/>	<input type="checkbox"/>	Spouse:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	
<input type="checkbox"/>	<input type="checkbox"/>	Child:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	
<input type="checkbox"/>	<input type="checkbox"/>	Child:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	

5. ENROLLMENT SELECTION (Select one):

Employee Only. Employee plus one Dependent.
 Employee and Spouse Employee plus two or more Dependents.
 Employee plus one Dependent Child Family – Employee and his/her Dependents.
 Employee plus two or more Dependent Children. Employee plus Child(ren).

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I understand that premiums for my coverage under the group policy will be remitted to the TruAssure Insurance Company by my Employer. If I must contribute to the premium for my coverage, I understand that arrangements for payroll deduction will be made by my Employer.

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

Signature of Employee _____

Date signed _____