TruAssure Insurance Company
111 Shuman Boulevard, Naperville IL 60563
(866) 922-6004

ENROLLMENT/CHANGE OF STATUS/WAIVER FORM FOR GROUP DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY COVERAGE

Please print or type all answers.

1. EMPLOYEE

Employee Name (First/Middle/Last)			Date of Hire *(mm/dd/yyyy)*
Date of Birth *(mm/dd/yyyy)*	Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Social Security Number or Alternate ID Number
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. ☐ Yes ☐ No			
I consent to receive policy related e-mails from TruAssure by e-mail. ☐ Yes ☐ 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
☐	☐	Spouse:		☐	☐	Child:	
☐	☐	Child:		☐	☐	Child:	
☐	☐	Child:		☐	☐	Child:	

5. ENROLLMENT SELECTION *(Select one):*

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

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

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.

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.

Signature of Employee _____ Date signed _____