Enrollment/Change of Status Form for Group Dental Policy

TruAssure Insurance Company is an Illinois domiciled Company.

ATTENTION: TruAssure Enrollment | FAX: (630) 381-4807 | PHONE: (866) 922-6004

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

MEMBER

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

Date of Hire ___/___/____	Gender ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Civil Union ☐ Domestic Partnership	Social Security Number or Alternate ID Number

Mailing Address	City	State	ZIP

Phone Number ( )	Email Address

Name of Employer	Group Number	Requested Effective Date of Coverage ___/___/____

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

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

MEMBER/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.

Are you and/or your dependent(s) covered by any other dental benefit program? ☐ Yes ☐ No

If "Yes," list the name of the carrier: ________________

REASON(S) FOR SUBMITTING THIS FORM

☐ **Initial or Open Enrollment**

☐ **COBRA**
End Date ___/___/_____

☐ **Retiree**

☐ **Reinstatement due to:**
☐ Rehire ☐ Loss of Other Coverage ☐ Other ____

☐ **Add Dependent due to:**
☐ Birth ☐ Adoption/Placement for Adoption ☐ Marriage ☐ Domestic Partnership ☐ Civil Union
☐ Legal Guardianship ☐ Loss of Other Coverage ☐ Dependent Child with Disability ☐ Military Dependent
☐ Court Order ☐ Other____________

Date of Qualifying Event ___/___/_____

CONTINUED ON NEXT PAGE

Enrollment/Change of Status Form for Group Dental Policy

REASONS FOR SUBMITTING THIS FORM (CONT'D)

☐ **Drop Dependent due to:**

☐ Age ☐ Death ☐ Divorced ☐ Other Coverage Elsewhere

Date of Qualifying Event ___/___/_____

☐ **Termination of Employment**

Date ___/___/_____

☐ **Covered Under Spouse, Domestic Partner, or Civil Union Partner**

Date ___/___/_____

☐ **Name Change**

Former Name ______________________ New Name ______________________

☐ **Address Change**

DEPENDENTS

Indicate the names of all dependents to be insured under the Group 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

ENROLLMENT SELECTION

Select one:

☐ **Member Only**	☐ **Member Plus One Dependent**
☐ **Member and Spouse**	☐ **Member Plus Two or More Dependents**
☐ **Member Plus One Dependent Child**	☐ **Family – Member and Dependents**
☐ **Member Plus Two or More Dependent Children**	☐ **Member Plus Child(ren)**

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.

PLEASE READ AND AGREE TO THE PRECEDING WARNING OR THE WARNING APPLICABLE TO YOUR STATE AND SIGN ON THE LAST PAGE OF THIS ENROLLMENT/CHANGE FORM.

CONTINUED ON NEXT PAGE

Enrollment/Change of Status Form for Group Dental Policy

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 if 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.

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.

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.

CONTINUED ON NEXT PAGE

Enrollment/Change of Status Form for Group Dental Policy

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.

THE COMMONWEALTH OF PENNSYLVANIA: DISCLAIMER: The English version of this form is the official version and shall control the resolution of any dispute or complaint. The Spanish version is provided as an accommodation to the customer and is for informational purposes only.

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.

CONTINUED ON NEXT PAGE

Enrollment/Change of Status Form for Group Dental Policy

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.

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.

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

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.

Signature of Member	**Date** ___/___/_____

CONTINUED ON NEXT PAGE

Enrollment/Change of Status Form for Group Dental Policy

Arabic
ال عرب ية
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.