



Plan Option: 1 2  
Circle One

TruAssure Insurance Company  
111 Shuman Boulevard, Naperville IL 60563  
(844) 350-4433

Area: 1 2 3 4  
Circle One

OHIO

APPLICATION FOR GROUP DENTAL  
PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

1. Proposed Effective Date of Group Policy _____			<input type="checkbox"/> New Application	<input type="checkbox"/> Change
<b>2. Employer Information – Group Policyholder</b>				
Legal Name of Group Policyholder				
Address (include County)				
Billing Address (if different)				
Phone Number		E-mail		Type of Business
Years in business	SIC Code	Type of Ownership: <input type="checkbox"/> Sole-Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation		
Employer Tax Identification Number			Employer Plan Number	
Group Administrator Contact			Title	
Administrator Contact Phone			E-mail	
Billing Contact (if different than above)		Billing Contact Phone	Billing Contact E-mail (if different than above)	
Billing Address (if different than above)				
Eligibility Contact (if different than above)		Eligibility Contact Phone	Eligibility Contact E-mail (if different than above)	
<b>3. Representations – Agreement</b>				

I agree: (1) that the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) that this application will be part of the group policy for which I apply; (3) I will notify TruAssure Insurance Company ("the Company") if any statements or answers given in this application change prior to policy delivery.

I understand that the group policy will be renewed each year on the policy anniversary date, unless I notify the Company to terminate the group policy. Such notification will be provided to the Company at least [45] days prior to the termination date. I understand that termination of group policy is subject to the terms and conditions provided in the group policy.

I understand and agree that:

- (1) the first month's estimated premium; and
- (2) fully completed enrollment information for all eligible persons requesting insurance coverage; must be submitted with this application **before** action can be taken on this application.

I understand and agree that: (1) coverage is not in effect unless and until I receive notification of acceptance from the Company; (2) if this application is declined, the Company will return any premium deposit submitted with this application; (3) the initial premium for the group policy must be paid in advance of the due date; (4) the Company will issue the group policy to me; and (5) the Company will provide me with employee certificate forms and Outline of Coverage forms, if applicable, that I must distribute to insured employees.

I understand that: (1) the Company will rely on the information I provide in this application: (a) in determining eligibility for the group policy coverage for which I apply; (b) in setting premium rates; and (c) for other enrollment purposes; and (2) any misrepresentation or fraudulent statement in the application may result in: (a) rescission of the group policy; (b) termination of coverage; or (c) other consequences as permitted by law.

I agree that the Company will be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under the group policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any insurer rights or requirements; and (c) waive any information that the insurer requests.

**READ YOUR POLICY 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.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Employer Applicant (Group Policyholder) Title Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Printed Name of Licensed Insurance Agent Signature of Licensed Insurance Agent Date

\_\_\_\_\_  
Agent License Number State of Agent License

**Binder Check:**

A binder check for the first month premium must be issued to process a new group. A photo copy must be submitted with the Application for Group Dental. The live check is made payable and mailed to:

VBA Dental  
300 Weyman Road, Suite 400  
Pittsburgh, PA 15236-1588  
Attn: Sherry Putt



**SUPPLEMENTAL QUESTIONNAIRE FOR  
 GROUP DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY**

<b>A. Employer Contribution:</b> <input type="checkbox"/> None - Coverage is voluntary <input type="checkbox"/> Employer Contribution <i>(Indicate the contribution below.)</i>	
Employer Contribution for Employee:    \$ _____ or _____ % per month	
Employer Contribution for Dependents: \$ _____ or _____ % per month	
<b>B. Enrollment Eligibility:</b> <i>Please indicate the employee eligibility requirements for enrollment under the group policy.</i>	
Enrollment under the group policy will include <i>(select all that apply)</i> :	
<input type="checkbox"/> All Full-Time Active Employees working _____ hours per week	
<input type="checkbox"/> All Part-Time Active Employees working _____ hours per week <input type="checkbox"/> Other _____ <input type="checkbox"/> Dependents	
<b>Enrollment Eligibility</b> <i>(Please select and complete the eligibility information.)</i>	
<input type="checkbox"/> Class 1: All full-time active employees:	
<input type="checkbox"/> Coverage is effective on the first of the month following date of employment.	
<input type="checkbox"/> Coverage is effective on the first of the month following _____ days of employment.	
<input type="checkbox"/> Coverage is effective on the first of the month following: _____	
<input type="checkbox"/> Coverage is effective on the date of hire.	
<input type="checkbox"/> Class 2:	
<input type="checkbox"/> Coverage is effective on the first of the month following date of employment.	
<input type="checkbox"/> Coverage is effective on the first of the month following _____ days of employment.	
<input type="checkbox"/> Coverage is effective on the first of the month following: _____	
<input type="checkbox"/> Coverage is effective on the date of hire.	
<b>C. Annual Open Enrollment Period:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes", specify the annual Enrollment Period date: _____	
<b>D. Initial Enrollment:</b> Total Number of Eligible Employees being enrolled: _____	Total Number of Employees Eligible for Enrollment: _____
<b>E. Remarks/Additional Information:</b>	
<b>F. Broker Information:</b> Appointment paperwork is also required	
Broker Name: _____	Agency Name: _____
Address: _____	City: _____
State: _____ Zip: _____ Phone: _____	Fax: _____ Email: _____
Broker Name: _____	Agency Name: _____
Address: _____	City: _____
State: _____ Zip: _____ Phone: _____	Fax: _____ Email: _____
<b>G. General Agency Information (If Applicable):</b>	
Broker Name: <u>Diane Barber</u>	Agency Name: <u>Capital Region Benefits</u>
Address: <u>3819 Market Street</u>	City: <u>Camp Hill</u>
State: <u>PA</u> Zip: <u>17011</u> Phone: <u>717-975-9300</u>	Fax: <u>717-975-9303</u> Email: <u>admin1@crbenefits.net</u>