TruAssure™ INSURANCE COMPANY

Plan Option: 1 2
Circle One

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 plus one Dependent.
☐ Employee plus two or more Dependents.

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 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 Employee Date signed