TruAssure™ INSURANCE COMPANY

Plan Option: 1 2
Circle One

Area: 1 2 3
Circle One

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

APPLICATION FOR GROUP DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

PENNSYLVANIA

1. Proposed Effective Date of Group Policy _____ ☐ New Application ☐ Change			
2. Employer Information – Group Policyholder			
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: ☐ Sole-Proprietorship ☐ Partnership ☐ 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)*	
3. Representations – Agreement			

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

TruAssure INSURANCE COMPANY

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

A. Employer Contribution: ☐ None - Coverage is voluntary ☐ Employer Contribution *(Indicate the contribution below.)*

Employer Contribution for Employee: $_____ or _____% per month

Employer Contribution for Dependents: $_____ or _____% per month

B. Enrollment Eligibility: *Please indicate the employee eligibility requirements for enrollment under the group policy.*

Enrollment under the group policy will include *(select all that apply)*:
☐ All Full-Time Active Employees working _____ hours per week
☐ All Part-Time Active Employees working _____ hours per week ☐ Other _____ ☐ Dependents

Enrollment Eligibility *(Please select and complete the eligibility information.)*
☐ Class 1: All full-time active employees:
- ☐ Coverage is effective on the first of the month following date of employment.
- ☐ Coverage is effective on the first of the month following _____ days of employment.
- ☐ Coverage is effective on the first of the month following: _____.
- ☐ Coverage is effective on the date of hire.

☐ Class 2:
- ☐ Coverage is effective on the first of the month following date of employment.
- ☐ Coverage is effective on the first of the month following _____ days of employment.
- ☐ Coverage is effective on the first of the month following: _____.
- ☐ Coverage is effective on the date of hire.

C. Annual Open Enrollment Period: ☐ Yes ☐ No If "Yes", specify the annual Enrollment Period date:

D. Initial Enrollment: Total Number of Eligible Employees being enrolled: | Total Number of Employees Eligible for Enrollment:

E. Remarks/Additional Information:

F. Broker Information: 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: _____

G. General Agency Information (If Applicable):

Broker Name: Diane Barber Agency Name: Capital Region Benefits

Address: 3819 Market Street City: Camp Hill

State: PA Zip: 17011 Phone: 717-975-9300 Fax: 717-975-9303 Email: admin1@crbenefits.ne