



**ENROLLMENT/CHANGE OF STATUS/WAIVER FORM**

Please print or type all answers.

**FOR GROUP DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY COVERAGE**

**1. EMPLOYEE**

Employee Name (First/Middle/Last)			Date of Hire (mm/dd/yyyy)
Date of Birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Single <input type="checkbox"/> Widowed
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. <input type="checkbox"/> Yes <input type="checkbox"/> No			
I consent to receive policy related e-mails from TruAssure by e-mail. <input type="checkbox"/> Yes <input type="checkbox"/> 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
<input type="checkbox"/>	<input type="checkbox"/>	Spouse:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	
<input type="checkbox"/>	<input type="checkbox"/>	Child:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	
<input type="checkbox"/>	<input type="checkbox"/>	Child:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	

**5. ENROLLMENT SELECTION (Select one):**

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

**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 \_\_\_\_\_