Supplemental Questionnaire for Group Dental Policy

ATTENTION: TruAssure Enrollment | FAX: (630) 983-4628 | PHONE: (888) 559-0781

POLICYHOLDER INFORMATION

Group Name ______________________ ☐ ASO ☐ Fully Insured

BENEFIT PERIOD

Deductible and Maximum Accumulation:

☐ Contract Year ☐ Calendar Year ☐ Other ______________

POLICYHOLDER CONTRIBUTION

☐ **None (Coverage is voluntary)**

☐ **Policyholder Contribution (Indicate the contribution below)**

$______ or ____ % of the cost of the **member's** insurance.

$______ or ____ % of the cost of the **dependents'** insurance.

Total number of eligibles: ______________ **Total number of enrollees:** ______________

ENROLLMENT ELIGIBILITY

PLEASE INDICATE THE MEMBER 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.
☐ All Members
☐ Dependents
☐ Domestic Partners / Dependents of Domestic Partners
☐ Retirees / Dependents of Retirees
☐ Other: ______________________________

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.
- ☐ Coverage terminates on: ________.

☐ **Class 2: ________ and after Coverage terminates on: ________.**

- ☐ 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.
- ☐ Coverage terminates on: ________.

INITIAL ENROLLMENT

Total Number of Eligible Members: ______________

Total Number of Eligible Members Enrolled: ______________

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MODE OF PREMIUM PAYMENTS

Fully Insured Groups: Binder Amount $ ____________ ☐ Wire Transfer ☐ Check

Administrative Fee—Self Funded:

The Group agrees to pay TruAssure for dental $ ______ per member per month for ____ months.

Prefund Amount: $ __________ ☐ Wire Transfer ☐ Check **OR** Weekly Payment: ☐ ACH Debit ☐ Wire Transfer

REMARKS/ADDITIONAL INFORMATION

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BROKER INFORMATION

Broker Name		Agency Name		
Mailing Address		City	State	ZIP
Phone Number ( )	Fax Number ( )	Email Address		
Broker Name		Agency Name		
Mailing Address		City	State	ZIP
Phone Number ( )	Fax Number ( )	Email Address		

GENERAL AGENCY INFORMATION (If Applicable)

Broker Name		Agency Name		
Mailing Address		City	State	ZIP
Phone Number ( )	Fax Number ( )	Email Address		

COMMISSIONS PAYABLE

☐ **Broker**

☐ **Agency**

Tax ID # for Commissions ____________________________

Please note: Attach your selected plan design with accepted rates when submitting this form.