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.

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 _____ days following date of hire.
- ☐ Coverage is effective on the date of hire.
- ☐ Coverage terminates on: _____.

☐ **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 _____ days following date of hire.
- ☐ Coverage is effective on the date of hire.
- ☐ Coverage terminates on: _____.

INITIAL ENROLLMENT

Total Number of Eligible: _____

Total Number of Eligible Enrolled: _____

CONTINUED ON NEXT PAGE

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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

_____

_____

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.