DentAssure Dental Plans
Employee Enrollment Form

For Company Use Only					
ER #		**Loc. #**		**Eff. Date**	

PLEASE PRINT IN SPACE PROVIDED ☐ **Active** ☐ **COBRA** ☐ **Cal COBRA**

EMPLOYER INFORMATION

EMPLOYER NAME	LOCATION	GROUP NO.

EMPLOYEE APPLICANT

LAST NAME	FIRST NAME	M.I.

STREET ADDRESS	CITY	STATE	ZIP

SOCIAL SECURITY NUMBER	TELEPHONE NUMBER	BIRTH DATE
	( )	/ /

SEX		FULL TIME EMPLOYMENT DATE	MARITAL STATUS		OCCUPATION / TITLE	EMPLOYMENT STATUS	
MALE	FEMALE		SINGLE	MARRIED		ACTIVE	INACTIVE
❑	❑	/ /	❑	❑		❑	❑

COVERAGE – Check Those That Apply

❑ EMPLOYEE ❑ SPOUSE ❑ CHILDREN ❑ MY FAMILY REQUESTED EFFECTIVE DATE: _____

DEPENDENT INFORMATION

	Last Name	First Name	MI	Date of Birth	Age	Sex	
Spouse				/ /			
Child				/ /			
Child				/ /			
Child				/ /			
Child				/ /			

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL COVERAGE? _____
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Fraud Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

REFUSAL/WAIVER – Complete Only If You Are Declining Coverage For Yourself Or Any Dependent

I DECLINE COVERAGE FOR: ❑ MYSELF ❑ MY SPOUSE ❑ MY CHILDREN ❑ MY FAMILY
REASON FOR REFUSAL:

_____

ACKNOWLEDGMENT AND AUTHORIZATION

By my signature below, I hereby request coverage as outlined above under the group dental or vision plan offered by my employer and authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice and understand that if I have declined any coverage on myself or eligible dependent and wish to enroll at a later date, coverage will be deferred in accordance with the plan provisions. I certify I have read the Fraud Notice above.

DATE	SIGNATURE
	X

Underwritten by:	***Administered by:***
TruAssure Insurance Company	***Integrity Administrators, Inc.***
111 Shuman Blvd	***P.O. Box 13128, Sacramento, CA 95813-3128***
Naperville, IL 60563	***Phone: (800) 562-9383 ♦ Fax (916) 921-3383***