

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.
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EMPLOYEE APPLICANT

LAST NAME	FIRST NAME	M.I.
STREET ADDRESS	CITY	STATE
		ZIP
SOCIAL SECURITY NUMBER	TELEPHONE NUMBER () -	BIRTH DATE / /
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	FULL TIME EMPLOYMENT DATE / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>
OCCUPATION / TITLE		EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>

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 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. Typing your name is the equivalent to an electronic signature

DATE / /	SIGNATURE X /s/
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<p><i>Underwritten by:</i> TruAssure Insurance Company 111 Shuman Blvd Naperville, IL 60563</p>	<p><i>Administered by:</i> Integrity Administrators, Inc. P.O. Box 13128, Sacramento, CA 95813-3128 Phone: (800) 562-9383 ♦ Fax (916) 921-3383</p>
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