TruAssure Insurance Company
111 Shuman Boulevard, Naperville IL 60563
(844) 350-4433

APPLICATION FOR GROUP DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

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

This policy does not offer pediatric Essential Health Benefits (EHB) as mandated under the Affordable Care Act.

1. Proposed Effective Date of Group Policy _____ ☐ New Application ☐ Change			
2. Employer Information – Group Policyholder			
Legal Name of Group Policyholder			
Address *(include County)*			
Billing Address *(if different)*			
Phone Number	E-mail	Type of Business	
Years in business	SIC Code	Type of Ownership: ☐ Sole-Proprietorship ☐ Partnership ☐ Corporation	
Employer Tax Identification Number	Employer Plan Number		
Group Administrator Contact	Title		
Administrator Contact Phone	E-mail		
Billing Contact *(if different than above)*	Billing Contact Phone	Billing Contact E-mail *(if different than above)*	
Billing Address *(if different than above)*			
Eligibility Contact *(if different than above)*	Eligibility Contact Phone	Eligibility Contact E-mail *(if different than above)*	
3. Representations – Agreement			

I agree: (1) that the statements and answers given in this application are true, complete, and correctly recorded to the best of my knowledge and belief; (2) that this application will be part of the group policy for which I apply; (3) I will notify TruAssure Insurance Company ("the Company") if any statements or answers given in this application change prior to policy delivery.

I understand that the group policy will be renewed each year on the policy anniversary date, unless I notify the Company to terminate the group policy. Such notification will be provided to the Company at least 45 days prior to the termination date. I understand that termination of group policy is subject to the terms and conditions provided in the group policy.

I understand and agree that:
(1) the first month's estimated premium; and
(2) fully completed enrollment information for all eligible persons requesting insurance coverage;
must be submitted with this application ***before*** action can be taken on this application.

I understand and agree that: (1) coverage is not in effect unless and until I receive notification of acceptance from the Company; (2) if this application is declined, the Company will return any premium deposit submitted with this application; (3) the initial premium for the group policy must be paid in advance of the due date; (4) the Company will issue the group policy to me; and (5) the Company will provide me with employee certificate forms and Outline of Coverage forms, if applicable, that I must distribute to insured employees.

I understand that: (1) the Company will rely on the information I provide in this application: (a) in determining eligibility for the group policy coverage for which I apply; (b) in setting premium rates; and (c) for other enrollment purposes; and (2) any misrepresentation or fraudulent statement in the application may result in: (a) rescission of the group policy; (b) termination of coverage; or (c) other consequences as permitted by law.

I agree that the Company will be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under the group policy. I understand and agree that I am responsible for notifying the Company promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of newly eligible employees or dependents.

No licensed insurance agent is authorized to: (a) make or modify contracts; (b) waive any insurer rights or requirements; and (c) waive any information that the insurer requests.

READ YOUR POLICY CAREFULLY.

California Fraud Notice: Any false statement or misrepresentation in this application may result in loss of coverage, subject to the Incontestability provision.

Signature of Employer Applicant (Group Policyholder)	Title	Date
Printed Name of Licensed Insurance Agent	Signature of Licensed Insurance Agent	Date
Agent License Number		State of Agent License

DentAssure PPO Dental Plans Supplemental Questionnaire	For Company Use Only					
	ER #		Agent #		Eff. Date	

PLEASE PRINT IN SPACE PROVIDED

NEW CASE SUBMISSION CHECKLIST AND QUESTIONNAIRE

Legal name of Employer Applicant (Policyholder):

Group's Contact Fax Number: For correspondences	( )
Group Application : Fully completed and Signed	☐
Supplemental Questionnaire:	☐
Employee Enrollment Forms:	☐
Prior Coverage Information: Most recent billing statement, and prior 12 months billing statement.	☐
Proposal: Final Sold Proposal.	☐
Premium Deposit Check: Payable to Integrity Administrators, Inc.	☐

Advance payment of $_____ is being submitted herewith to be applied by the Company to premiums for insurance when and if issued.

ELIGIBILITY

The term "eligible employees", when used below, means actively working full-time employee (working a minimum of 20 hours or more per week) who have completed their waiting period.

		Please explain any differences.
(A) Total No. of all employees (full-time, part-time, seasonal, etc.)	_____	
(B) Total No. of eligible employees	_____	_____
(C) Total No. of eligible employees enrolled	_____	_____
(D) Total No. of eligible employees with dependents	_____	_____
(E) Total No. of eligible employees who enrolled dependents	_____	_____
(F) Total No. of eligible employees in their waiting period	_____	_____

(G) Are there any classes of full-time employees excluded from coverage? ☐ Yes ☐ No If yes, describe the class. _____

(H) **A copy of your Employee Quarterly Wage Report (if applicable) must accompany this application.**

Waiting Periods: Number of months for employees hired after the requested effective date is _____

Coverage will be effective the first of the month following the stated waiting period.

Employer Dental Contribution Level

❑ 100% Employer Paid OR _____ % Employer Paid for both employee and dependent coverage. ☐ Voluntary Plan

OR the following Employer Contribution Level: For Employees: ____ % or $_____ For Dependents: ____ % or $_____

PRIOR CARRIER INFORMATION

If the insurance applied for replaces, or is in addition to, any similar group or wholesale insurance now or previously in force, give the carrier, the type of coverage and the date the insurance was or is to be discontinued.

Carrier Name	Type of Coverage	Termination Date

For Prior Coverage Credit to be considered, this application must be accompanied by a current month's billing from the current carrier, a copy of an in-force certificate and benefit schedule as well as proof of the effective date for each Insured Individual (and dependents, if insured).

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

– PLEASE COMPLETE OTHER SIDE –

SCHEDULE OF BENEFITS

PPO PLAN

Deductible (waived for Preventive procedures): ☐ $0 ☐ $25 ☐ $50 ☐ $75 ☐ $100

Calendar Year Maximum: ☐ $1,000 ☐ $1,250 ☐ $1,500 ☐ $2,000 ☐ $ 2,500

PPO Coverage Levels:

Preventive: _____% In PPO / _____% Non PPO

Basic: _____% In PPO / _____% Non PPO

Major: _____% In PPO / _____% Non PPO

ENDODONTIC / PERIODONTIC BENEFIT OPTION*

Endodontic / Periodontic Benefits: ☐ Covered Under Basic Benefits ☐ Covered Under Major Benefits

**To qualify for Basic Benefits, the employer must have at least 5 employees enrolling in the dental plan.*

ORTHODONTIC BENEFIT OPTION*

Orthodontic Benefits: ☐ Yes ☐ No Benefit Level: ☐ $1,000 Lifetime Maximum ☐ $1,500 Lifetime Maximum ☐ Child(ren) only ☐ Child(ren) and Adult

**To qualify for orthodontic benefits, the employer must have at least 5 employees enrolling in the dental plan. Not available on Voluntary Groups.*

COBRA

Is this group: ☐ COBRA ☐ Cal COBRA

Does group currently have COBRA participants? ☐ Yes ☐ No

If yes, please indicate names:_____

Are you electing to have Integrity Administrators administer COBRA for the group? ☐ Yes ☐ No

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

AGREEMENT AND SIGNATURES

It is understood and agreed as follows:

1. No coverage is effective until approved by TruAssure Insurance Company.
2. Insurance will be effective with regard to those individuals listed in the Eligibility Section on the later of the following dates: (a) the effective date approved by the Company; (b) the date this application is signed; or (c) the date the first premium is paid in full.
3. To the best of my knowledge and belief, all the statements and answers given in this questionnaire are true and complete.
4. I understand and agree that (a) no agent may change or waive any of the provisions of this application or of any plan of insurance; (b) any change or waiver may be made only by an officer of TruAssure Insurance Company; and (c) this application will be accepted or declined partly on the basis of the statements and answers given in this application.

FRAUD STATEMENT: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Dated at: _____ this _____ day of _____, _____

X _____ Signature of Writing Agent

_____ Tax I. D. Number

X _____ Signature of General Agent

X _____ Signature of Other Agent(s)

( ) _____ Phone Number

_____ Agency Name

_____ Agent's e-mail Address

X _____ General Agent

_____ General Agent Tax I.D.

SPECIAL REQUESTS

Send Administration Kit, Certificates, and ID Cards to: ☐ Broker ☐ Policyholder