



**ENROLLMENT/CHANGE OF STATUS/WAIVER FORM**

Please print or type all answers.

**FOR GROUP DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) POLICY COVERAGE**

**1. EMPLOYEE**

Employee Name (First/Middle/Last)			Date of Hire (mm/dd/yyyy)
Date of Birth (mm/dd/yyyy)	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Single <input type="checkbox"/> Widowed
Home Address (Street, City, State, County, Zip Code)		Home Phone Number	E-mail Address
I consent to receive any communications from TruAssure by e-mail. <input type="checkbox"/> Yes <input type="checkbox"/> No			
I consent to receive policy related e-mails from TruAssure by e-mail. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Employer		Group Number	Effective Date of Coverage

**2. EMPLOYEE / DEPENDENT / ADDITIONS / TERMINATIONS / CHANGES**

Please check one of the options below:  
 **Yes**, I want to enroll in this Group Coverage  
 **No**, I do not want to enroll in this Group Coverage. If "No", do you have other dental insurance coverage?  Yes  No

**3. REASONS FOR SUBMITTING THIS FORM**

Initial or Open Enrollment     COBRA    COBRA End Date \_\_\_\_/\_\_\_\_/\_\_\_\_     Retiree  
 Reinstatement due to:     Rehire     Loss of Other Coverage     Other \_\_\_\_\_  
 Add Dependent (list below) due to:  
 Birth     Adoption     Marriage     Domestic Partnership     Loss of Other Coverage     Legal Guardianship  
 Disabled Dependent     Military Dependent     Other \_\_\_\_\_  
 Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Drop Dependent (list below) due to:  
 Age     Death     Divorce     Other Coverage Elsewhere    Date of Qualifying Event \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Termination of Employment    Date \_\_\_\_/\_\_\_\_/\_\_\_\_     Covered Under Spouse    Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Name Change (Former Name \_\_\_\_\_)     Address Change

**4. DEPENDENTS: (Indicate the names of all dependents to be insured under the Group Policy.)**

ADD	DELETE	NAME	DATE OF BIRTH	ADD	DELETE	NAME	DATE OF BIRTH
<input type="checkbox"/>	<input type="checkbox"/>	Spouse:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	
<input type="checkbox"/>	<input type="checkbox"/>	Child:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	
<input type="checkbox"/>	<input type="checkbox"/>	Child:		<input type="checkbox"/>	<input type="checkbox"/>	Child:	

**5. ENROLLMENT SELECTION (Select one):**

<input type="checkbox"/> Employee Only.	<input type="checkbox"/> Employee plus one Dependent.
<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee plus two or more Dependents.
<input type="checkbox"/> Employee plus one Dependent Child	<input type="checkbox"/> Family – Employee and his/her Dependents.
<input type="checkbox"/> Employee plus two or more Dependent Children.	<input type="checkbox"/> Employee plus Child(ren).

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I understand that premiums for my coverage under the group policy will be remitted to the TruAssure Insurance Company by my Employer. If I must contribute to the premium for my coverage, I understand that arrangements for payroll deduction will be made by my Employer.

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Signature of Employee \_\_\_\_\_ Date signed \_\_\_\_\_



## Discrimination is Against the Law

TruAssure complies with all applicable Federal and State civil rights laws. TruAssure does not discriminate, exclude people, or treat them differently on the basis of gender, sex (which includes discrimination on the basis of sex characteristics, including Intersex traits; pregnancy or related conditions; sexual orientation; gender identity or expression; and sex stereotypes), race, color, religious creed, national origin, citizenship, age, physical or intellectual disability, protected veteran status, marital status, genetic information, or any other characteristic protected by law.

### TruAssure:

- Provides free auxiliary aids and services to individuals with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, braille, audio, accessible electronic formats, etc.)
  - Provides free language assistance services to people whose primary language is not English, such as:
    - Qualified interpreters for oral interpretation
    - Electronic and written translated documents in other languages
- If you need these services, contact our Civil Rights Coordinator. If you believe that TruAssure has failed to provide these services or discriminated in any way, you can file a grievance with:

Civil Rights Coordinator  
TruAssure  
111 Shuman Boulevard  
Naperville IL 60563  
Phone: [630-718-4995](tel:630-718-4995)  
Email: [compliance@truassure.com](mailto:compliance@truassure.com)

You can file a grievance in person or by mail, phone or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
[1-800-368-1019](tel:1-800-368-1019), [800-537-7697](tel:800-537-7697) (TDD)

Complaint forms are available at <https://hhs.gov/ocr/office/file/index.html>  
This notice is available at TruAssure's website at <https://www.truassure.com/nondiscrimination-notice.html>

العربية (Arabic)	تنبیه: إذا اکتدت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتسهيقات يمكن الوصول إليها مجانًا. اتصل على ال 1-888-559-0779 أو تحدث إلى مقدم الخدمة.
繁體中文 (Chinese)	注意：如果您說中文，我們可以為您提供免費語言協助服務。您也可以免費提供適當的輔助工具與服務，以無障礙格式提供資訊。請致電 1-888-559-0779 或與您的提供者討論。
Français (French)	ATTENTION: Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-559-0779 ou parlez à votre fournisseur.
Kreyòl Ayisyen (French Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sevis ed aladiapoziyòn w gratis pou lang ou pale a. Ed ak sevis siplemante apwopriye pou bay enfòmasyon nan fòm aksepsib yo disponib gratis tou. Rele nan 1-888-559-0779 oswa pale avèk founisè w la.
Deutsch (German)	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-559-0779 an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી (Gujarati)	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય આધિકારી સહાય અને એક્સ્ટ્રિયાલ શોર્ટ્કટ્સ માલિકી પૂરી વાસ્તવ માટેની સેવાઓ પણ વિના ખૂલે ઉપલબ્ધ છે. 1-888-559-0779 પર શોધ કરો અથવા તમારા પ્રદાતા સેવા વાત કરો.
हिंदी (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी नि:शुल्क उपलब्ध हैं। 1-888-559-0779 पर कॉल करें या अपने प्रदाता से बात करें।
Italiano (Italian)	ATTENZIONE: se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama il 1-888-559-0779 o parla con il tuo fornitore.
日本語 (Japanese)	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-888-559-0779 までお電話ください。または、ご利用の事業者にご相談ください。
한국어 (Korean)	주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-559-0779 번으로 전화하거나 서비스 제공업체에 문의하십시오.
Português (Portuguese)	ATENÇÃO: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-888-559-0779 ou fale com seu provedor.
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-559-0779 или обратитесь к своему поставщику услуг.
Español (Spanish)	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-559-0779 o hable con su proveedor.
Tagalog (Tagalog – Filipino)	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxilyaryo na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-559-0779 o makipag-usap sa iyong provider.
Tiếng Việt (Vietnamese)	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-559-0779 hoặc trao đổi với người cung cấp dịch vụ của bạn.