

Verification of Eligibility

Participation requirements are a condition of coverage. These requirements will vary depending upon the plan selected. Please complete this form to verify eligibility. Statements made herein may be used to contest a claim of the validity of any policy issued. If a policy is issued, please see such policy for more information.

1. Employer's name and phone number _____
 Group Number _____
2. Total number of employees on payroll _____
3. Total number of employees working 1-29 hours per week (include temporary and/or seasonal employees) _____
4. Total number of employees in waiting period _____
5. Number of full-time eligible employees (subtract numbers 3 and 4 from number 2) _____

If you have purchased an employee paid voluntary group dental product, participation percentages are calculated from the number of full time employees shown in number 5 above. No waivers for coverage under another program will be allowed in this calculation.

For employer paid group coverage (with rates calculated from a census), the number of employees listed in number 6 and 7 below may be subtracted from the number of full time employees shown in number 5 above. Participation requirements will be calculated from that number.

6. Total number of employees enrolled in a DHMO or qualified Discount/Referral plan (proof must be submitted) _____
7. Total number of employees who are covered under their spouse's plan (an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file) _____
8. Number of eligible employees (subtract 6 & 7 from 5) _____
9. Number of full-time employees enrolled _____
10. Premium information: _____ 100% employer paid **OR** employer pays _____% of employee premium and _____% of dependent premium.

Agreement and Signatures

It is understood and agreed as follows:

1. No coverage is effective until approved by IHC Health Solutions, Inc.
2. Insurance will be effective with regard to those individuals listed in the Eligibility section of the application on the latest of the following dates: a) effective date approved by the company, b) the date the application is signed, or c) the date the first premium is paid in full.
3. No agent has the authority to waive any of the company's right or requirements, or to make or alter any contract or policy.

Dated at: _____ this _____ day of _____, 200__.

Signature of Writing Agent _____ Agent Code _____

Type or Print Agent's Name(s) _____

Agent's Business Address (City, State & Zip Code) _____

Agency _____ Agency Code _____

Applicant's Signature _____

Type or Print Name _____

Title _____

Company Name _____

