



## VERIFICATION OF ELIGIBILITY (VOE)

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 \_\_\_\_\_
2. Total number of employees on payroll \_\_\_\_\_
3. Number of full-time eligible employees \_\_\_\_\_
4. Number of employees waiving due to spousal coverage \_\_\_\_\_  
(an enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file)
5. Total Number of eligible employees \_\_\_\_\_  
(subtract numbers 4 from 3)

If you have purchased a group dental product, participation percentages are calculated from the number of full time employees shown in number 5 above.

6. Number of full-time employees enrolled \_\_\_\_\_

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### Agreement and Signatures

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It is understood and agreed as follows:

1. No coverage is effective until approved by The Dental Care Plus Group.
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

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Type or Print Agent's Name(s)

\_\_\_\_\_  
Type or Print Name

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency

\_\_\_\_\_  
Company Name