The Dental Care PLUS GROUP
The plus is service.

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. Total number of employees Eligible for benefits _____

4. Number of employees waiving due to spousal coverage _____
   (enrollment form with a signed waiver indicating such spouse's carrier must be submitted or on file)

5. Total Number of Eligible employees_____
   (subtract number 4 from number 3)

6. Total Number of full-time employees Enrolled _____

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

Agreement and Signatures

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_____, 20____.

_____	_____
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