

"Uniting People & Benefits"



## 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 and phone number \_\_\_\_\_  
GroupNumber \_\_\_\_\_
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 GroupLink, 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

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

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

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

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Agency      Agency Code

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