



Texas Ag Coop Trust Dental Application

The following form should be filled out completely and accurately. Please type or print neatly using black ink.

GROUP INFORMATION

Group Name:

Street Address: _____

City: _____

Zip Code: _____

Mailing Address: _____

City: _____

Zip Code: _____

Telephone Number: _____

Fax Number: _____

Website Address: _____

Type of entity:

Proprietorship
 Government

Partnership
 Non-Profit

Corporation
 Other _____

Association

Description of Business: _____

Tax ID: _____

Standard Industry Code (SIC): _____

Years in Business: _____

Location of corporate/parent headquarters:

Same as above

Other _____

Are other divisions, subsidiaries or affiliates covered under this plan?

No

Yes

If yes, please list below:

Name

Location

Relationship

Primary Contact Person: _____

Title: _____

Telephone Number: _____

Fax Number: _____

Email Address: _____

Form: TACT-Dental Application (11/06) Administered By: Total Administrative Services Corporation
2302 International Lane,
P.O. Box 14140
Madison, Wisconsin 53704-3140



Texas Ag Coop Trust
Dental Application (continued)

PARTICIPATION AND ELIGIBILITY REQUIREMENTS

Description of eligible employees: All full time employees Other _____

Are any employees excluded from eligibility? No Yes If yes, describe: _____

Note: Employees must work a minimum of 30 hours per week in order to be eligible for coverage. The waiting period for all employees is 30 days, with coverage to be effective the first of the month following completion of the waiting period.

Total number of full-time employees: _____

Total number of part-time employees: _____

Total number of eligible employees: _____

Total number of employees enrolling in this plan: _____
(Minimum participation is 75% of eligible employees.)

Total number of COBRA eligible members enrolling: _____
(Prior carrier COBRA election forms must be submitted.)

Total number of employees waiving coverage: _____

Total number of employees in the waiting period: _____

Employer Contributions:

	<i>Line of Coverage</i>			<i>Dental</i>
For employee coverage	<input type="checkbox"/> %	<input type="checkbox"/> \$	_____	
For dependent coverage	<input type="checkbox"/> %	<input type="checkbox"/> \$	_____	

AUTHORIZATION

I, the undersigned, understand and agree to the following...

- 1) Acceptance of this group for coverage and the final rates are based upon the information contained herein and the census of actual enrollees. Any material misrepresentation, whether intentional or unintentional, will permit TACT to terminate such coverage and to pursue all other legal remedies available.
- 2) Terms and conditions stated in this document as attested by the signature below, effective on the date of the signature.
- 3) TACT Privacy Policy Statement. (copy of which is on the TACT website)

Name: _____ Title: _____ Company: _____

Signature: _____ Date: _____