



Membership Enrollment Form

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INSTRUCTIONS PROVIDED ON BACK

PART A – EMPLOYEE INFORMATION

Employee's Name:		Last		First		Middle Initial		Social Security Number	
		/		/				/	
Gender:		Male Female		Marital Status:		Single Married Widowed Divorced Legally Separated		Date of Birth (Month-Day-Year)	
		<input type="checkbox"/> <input type="checkbox"/>				<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		/ /	
Employee's Address:		Address				Home Phone Number		Work Phone Number	
		City		State		Zip Code			

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		Complete If Multiple Plan Options Are Offered	
<input type="checkbox"/> Employee Only* <input type="checkbox"/> No Coverage* <input type="checkbox"/> Employee and Spouse * If waiving coverage for employee and/or any eligible family members, you must complete Part D. <input type="checkbox"/> Employee and Dependent Child(ren) <input type="checkbox"/> Family		I elect to participate in the following Plan: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D	

PART C – DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	If Over Age 19, Full-Time Student?
Spouse		M	F	/ /	
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

PART D – WAIVE COVERAGE

Do you (the employee) have other dental coverage? Yes No Do your dependents have other dental coverage? Yes No

Name of Carrier: _____ Policy/Identification Number: _____

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Securian Dental reserves the right to decline any further enrollment changes.

Employee Signature: _____ **Date:** _____

PART E – EMPLOYEE SIGNATURE

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: _____ **Date:** _____

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> New Group Hire Date: ____/____/____ Effective Date: ____/____/____		<input type="checkbox"/> Rehire Date Lay Off Began: ____/____/____ Date Rehired: ____/____/____	
<input type="checkbox"/> Existing Securian Dental Group Changing Plan Hire Date: ____/____/____ Prior Coverage Start Date (if applicable): ____/____/____ Effective Date: ____/____/____		<input type="checkbox"/> Return from Leave of Absence Date Leave Began: ____/____/____ Date Returned to Work: ____/____/____	
<input type="checkbox"/> Open Enrollment Coverage Effective Date: ____/____/____		<input type="checkbox"/> Employee Change Part Time to Full Time Date of Status Change: ____/____/____ Effective Date: ____/____/____	
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Coverage Effective Date Hire Date: ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Loss of Coverage – Employee and/or Dependent Hire Date: ____/____/____ Date of Loss: ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Previously Waived Coverage – Qualifying Event Reason: _____ Hire Date: ____/____/____ Event Date: ____/____/____ Effective Date: ____/____/____	
Group Name: _____		Group & Subgroup Numbers: _____	
Group Representative's Signature: _____		Date: _____ Phone Number: () _____	

Instructions for Completion of Securian Dental Enrollment Form

Important Notes:

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format.
- Before submitting, review to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt by Securian Dental Plans.

Employee – Complete PARTS: A, B, C, D, E

PART A: EMPLOYEE INFORMATION – Complete All Sections

PART B: ENROLLMENT INFORMATION

Select Coverage Type

- Select one category that describes your eligible dependents that you want covered under your dental plan.
- If you select *No Coverage*, you and your eligible dependents will not be enrolled and coverage is waived. If this option is selected, you must complete Part D.

Plan Options – Complete if Group Offers Multiple Benefit Plan Options

- Select only one option: Plan A, Plan B, Plan C or Plan D.

PART C: DEPENDENT INFORMATION – Complete Only if Enrolling Eligible Dependents

- Complete each section for each eligible dependents being enrolled.
- If enrolling more than four dependents, attach a list of additional dependent information in the same format.

PART D: WAIVE COVERAGE

- This section must be completed if in Part B you selected *Employee Only* and have eligible dependents or if you selected *No Coverage*.
- Complete other insurance coverage information.
- Check box to indicate you waive coverage.
- Sign and date the form as verification of your selection.

PART E: EMPLOYEE SIGNATURE

- Please read, sign and date the form as verification of your selection.
- If you selected *No Coverage* in Part B and completed Part D, a signature is not required in Part E.
- Return completed form to your benefit administrator.

Employer Complete PART F: GROUP ENROLLMENT INFORMATION

- Review sections completed by employee to assure information provided is complete, accurate and legible.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., first of the month, end of month, or actual dates).
- Check one section that describes reason Membership Enrollment Form is being submitted.
- Complete all dates in applicable section:
 - Hire Date – Date employee was employed by group.
 - Effective Date – Date the individual's dental benefits begin.
 - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Provide effective date of group's prior qualified dental plan. Date does not apply if group did not previously have a qualified dental plan.
 - Event Date – Date of qualifying event that allows additions or changes to employee's enrollment selection (i.e., date of marriage, date of divorce, date of adoption, etc.)
- **New Group** – New customer to Securian Dental and submitting initial employee enrollment. Complete all dates.
- **Existing Securian Dental Group Changing Plan** – Existing Securian Dental customer changing benefits from Plan A to Plan B or Plan C and submitting employee enrollment. Complete all dates.
- **New Hire** – Enroll newly hired employee. If probationary period applies, effective date is after the probationary period.
- **Rehire** – Former employee was laid off and is being rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other dental coverage and is now eligible to enroll.
- **Previously Waived Coverage** – Enrolled employee had eligible family status change such as: marriage, divorce, birth, adoption, which allows dependents to be added.
- **Employee Change Part-Time to Full-Time** – Employee's employment status changed and employee is now eligible for dental benefits.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Form To:

Securian Dental Plans
DeCare Dental Health International, LLC
Attn: Enrollment Department
PO Box 9385
Minneapolis MN 55440-9385