



# Membership Enrollment Form

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## INSTRUCTIONS PROVIDED ON BACK

### PART A – EMPLOYEE INFORMATION

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

### PART B – ENROLLMENT INFORMATION

<b>Select Coverage Type (Check One Box Only):</b>		<b>Complete If Multiple Plan Options Are Offered</b>	
<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. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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

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

# 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