Membership Enrollment Form

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PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

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) / /
Employee's Address: Address		Day Phone Number	Evening Phone Number
City	State	Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):

☐ Employee Only*
☐ Employee and Spouse
☐ Employee and Dependent Child(ren)
☐ Family

☐ No Coverage*

*** If waiving coverage for employee and/or any eligible family members, you must complete Part D.**

Complete If Multiple Plan Options Are Offered

I elect to participate in the following Plan:
☐ Plan A ☐ Plan B ☐ Plan C ☐ 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	Full Time Student?		Unmarried?	
Spouse		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

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 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 may commit 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

☐ **New Group**
Hire Date: _______/_______/_______
Effective Date: _______/_______/_______

☐ **Rehire**
Date Lay Off Began: ________/________/________
Date Rehired: ________/________/________

☐ **Existing Securian Dental Group Changing Plan**
Hire Date: _______/_______/_______
Prior Coverage Start Date (if applicable): _______/_______/_______
Effective Date: _______/_______/_______

☐ **Return from Leave of Absence**
Date Leave Began: ________/________/________
Date Returned to Work: ________/________/________

☐ **Employee Change Part Time to Full Time**
Date of Status Change: ________ /________/________
Effective Date: ________ /________/________

☐ **Open Enrollment**
Coverage Effective Date: _______/_______/_______

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Coverage Effective Date
Hire Date: _______/_______/_______
Effective Date: _______/_______/_______

☐ **Loss of Coverage** – Employee and/or Dependent
Hire Date: _______/_______/_______
Date of Loss: _______/_______/_______
Effective Date: _______/_______/_______

☐ **Previously Waived Coverage** – Qualifying Event Reason: ________________________
Hire Date: _______/_______/_______
Event Date: _______/_______/_______
Effective Date: _______/_______/_______

Group Name: **Group & Subgroup Numbers**:

Group Representative's Signature: **Date:** **Phone Number:** ( )

Employer Instructions

- Review Parts A, B, C, D, E to assure the employee provided complete, accurate and legible information.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., 1st of month, end of month, or actual dates).

Employer Complete PART F: GROUP ENROLLMENT INFORMATION

- Check one section that describes reason Membership Enrollment Form is being submitted.
- Complete all dates in applicable section:
  - Hire Date – Date the 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 231
  Minneapolis MN 55440-0231