



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) / /
Employee's Address: Address Home Phone Number Work Phone Number
City State Zip Code
Check If New Address

PART B - CHANGE REQUEST - Check All Categories That Apply - Provide Information Requested By Category

Name Change, Terminate Employee and All Dependent Coverage, Change Employee Group/Subgroup, Change Plan Option at Open Enrollment, Change Coverage Type Due to Qualifying Event
Qualifying Event Code Coverage Type Change Request Category Date of Qualifying Event Effective Date of Change

PART C - DEPENDENT INFORMATION - Adding or Dropping Dependents May Require a Coverage Type Change in Part B

Table with columns: Add Drop, Relationship To Employee, First Name, Middle Initial, Last Name, Gender, Date of Birth, Full Time Student?, Unmarried?

PART D - EMPLOYEE SIGNATURE - See Instructions for additional information.

I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. Employee Signature: Date:

PART E - COBRA - Employee Note: Complete Only if enrolling for COBRA benefits Employer Note - May require subgroup change

Select One: Group Billed Direct Billed
Select Qualifying Event Number: 1 Employee Termination or Reduction of Work Hours 2 Employee Death 3 Employee Total Disability 4 Divorce or Legal Separation 5 Employee Eligible For Medicare 6 Dependent No Longer Eligible
Coverage Continuation Applies To: Event Number Date of Qualifying Event Social Security Number

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

Group Name: Group & Subgroup Numbers:
Group Representative's Signature: Date: Phone Number: ()

Instructions for Completion of Membership Maintenance Form

Important Information:

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.

Important Notes:

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

PART A: EMPLOYEE INFORMATION – Complete all sections.

PART B: CHANGE REQUEST – Check one or more categories that apply and provide information as requested by category.

- **Name Change** – Provide name as previously reported and new name.
- **Terminate Employee and All Dependents** – Only use this section if the employee and all dependent coverage is being terminated.
- **Change Employee Group/Subgroup** – Move employee from one group/subgroup number to another for benefit, reporting or COBRA purposes.
- **Change Plan Option** – Applies only to employer groups that offer more than one Plan Option and have Open Enrollment. An employee may select a new Plan Option during the Group's Open Enrollment.
- **Coverage Type Change** – Complete this section to change *Coverage Type* and to add or drop dependent coverage. *Coverage Type* change requires a qualifying event (i.e., marriage, divorce, etc.) List Qualifying Event Code on line next to correct Coverage Type. Provide detailed information for each dependent being added or dropped in Part C.

PART C: DEPENDENT INFORMATION

- List dependents to be added or dropped when making a change to *Coverage Type* in Part B.
- Complete all sections for each dependent.
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

PART D: EMPLOYEE SIGNATURE

- Please read, sign and date form as verification of your change request.
- Return completed form to your benefit administrator.

Part E: COBRA

- Indicate whether the COBRA benefits are Group Billed or Direct Billed.
- Direct Billed means the employee is billed by Patriot Mutual and makes payments directly to Securian Dental.
- Group Billed means COBRA is billed by Securian Dental, the Group receives payment from the employee. The Group then pays Securian Dental for COBRA continuation.
- Select a coverage type election, the appropriate Qualifying Event Reason Code and provide the date of the qualifying event.
- If employee is not being enrolled for COBRA, provide the Social Security Number of the individual who is being enrolled.
- If your group has separate COBRA subgroup, it must be provided in Part B.
- Do not send Direct Billed COBRA requests to the Enrollment Department. To avoid delays or termination of benefits send all Direct Billed information to:
Securian Dental Plans
Attention: Coverage Continuation
PO Box 231
Minneapolis MN 55440-0231

PART F: GROUP INFORMATION – Completed By Employer

- **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