SECURIAN®

# Disabled Dependent / Michelle's Law Application

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**PARTS A, B, and C TO BE COMPLETED BY EMPLOYEE (Please Print)**

## PART A – EMPLOYEE INFORMATION

| | | | | |
|---|---|---|---|---|
| **Employee's Name:** | Last | First | Middle Initial | **Social Security Number** / / |
| **Employee's Address:** | Address | | Home Phone Number ( ) | Work Phone Number ( ) |
| | City | | State | Zip Code |
| **Group Name:** | | | | **Group Number:** |

## PART B – DEPENDENT CHILD INFORMATION – **Application for:** **Disabled Dependent** ☐ **Michelle's Law** ☐

| | | |
|---|---|---|
| **Dependent Child's First Name, Middle Initial, Last Name:** | **Gender** ☐ M ☐ F | **Date of Birth** (Month-Day-Year) / / |
| **Relationship to Employee:** | **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced | **Date Disability or Change from Full Time Student Occurred:** (Month-Day-Year) / / |

**Does Child Reside In Your Household?** ☐ Yes ☐ No If "No," provide an explanation.

| | | |
|---|---|---|
| **Is Child a Full Time Student?** ☐ Yes ☐ No | **Is Child Dependent Upon You For Support?** ☐ Yes ☐ No | **What Percentage of Support Do You Provide?** |
| **Was Child Listed as a Dependent On Your Last Federal Income Tax Return?** ☐ Yes ☐ No | **Has Child Ever Been Employed?** ☐ Yes ☐ No | **Is Child Currently Employed?** ☐ Yes ☐ No |

| **If Child Has Been or Is Currently Employed List Employer Name and Address** | **Employment Start Date** | **Employment End Date** |
|---|---|---|
| | / / | / / |
| | / / | / / |

**Name of Attending Physician Certifying Disability:**

| | | | |
|---|---|---|---|
| **Physician's Address:** | Address | | Office Phone Number |
| | City | State | Zip Code |

## PART C – EMPLOYEE SIGNATURE

I am requesting continued coverage for this dependent and authorize payroll deductions, as 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. I authorize health and dental care providers, third party payers, my employer, and state or federal agencies to exchange all demographic and dental information with Securian Dental of Minnesota or its designees necessary for claims processing, plan administration, and benefit determination. I give this consent for myself and any eligible family members listed on this application for which I am authorized to do so. I understand that failure to sign this authorization may be basis for enrollment or benefit denial. I understand this authorization remains in effect until coverage under this plan ends or I give written notice to Securian Dental that I want to revoke this authorization. I understand that revocation of this authorization may be a basis for denying benefits.

**Employee Signature:** _____ **Date:** _____ **Dependent Child's Signature:** _____ **Date:** _____

**Note:** Return completed forms to your employer for authorization and submission to Securian Dental.

## PART D – ATTENDING PHYSICIAN INFORMATION **-- TO BE COMPLETED BY ATTENDING PHYSICIAN**

**Date of injury or date disability/illness began?**

**Is child incapable of self-support due to a disability/illness/injury**? ☐ Yes ☐ No

**Is child able to attend school on a part time basis?** ☐ Yes ☐ No **Full time basis?** ☐ Yes ☐ No

**Date child is expected to return to school full time?** **Expected length of disability? (**Estimate Months or Years)

**Reason or Nature Of Disability/Illness/Injury:**

**Physician Signature:** **Date:**

## PART E – GROUP INFORMATION **-- TO BE COMPLETED BY EMPLOYER**

Mailing Address for Customers in **ME, NH, and VT**: Securian Dental Plans ◆ DeCare Dental Health International, LLC ◆ Attention: Enrollment Department ◆ PO Box 231 ◆ Minneapolis MN 55440-0231

Mailing Address for Customers in **All Other States**:
Securian Dental Plans ◆ DeCare Dental Health International, LLC ◆ Attention: Enrollment Department ◆ PO Box 9385 ◆ Minneapolis MN 55440-9385

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