



Membership Maintenance 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		
<input type="checkbox"/> Check If New Address	City		State		Zip Code				

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

<input type="checkbox"/> Name Change Former Name: _____ New Name: _____	<input type="checkbox"/> Terminate Employee and All Dependent Coverage Date of Termination: ____/____/____ Date Coverage Ends: ____/____/____		
<input type="checkbox"/> Change Employee Group/Subgroup (Move individual to different group/subgroup number, including COBRA subgroup) From: _____ To: _____ Effective Date of Change: ____/____/____	<input type="checkbox"/> Change Plan Option at Open Enrollment (Applies only if Group offers multiple Plan Options) 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		
<input type="checkbox"/> Change Coverage Type Due to Qualifying Event – List Qualifying Event Code next to correct Coverage Type and complete Part C if Adding or Dropping Dependents Qualifying Event Code: A – Adoption B – Birth D – Divorce/Legal Separation E – Death L – Loss of Coverage M – Marriage O – Group Open Enrollment S – Dependent No Longer Eligible			
Qualifying Event Code	Coverage Type Change Request Category	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /

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

Add Drop	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 - EMPLOYEE SIGNATURE – See back for additional information.

I choose to make changes as indicated on this form and authorize payroll deduction, if applicable. I understand and acknowledge that this Plan contains waiting periods for specified services. I further acknowledge that missing teeth are considered to be a pre-existing condition for which coverage is not available for the first twelve (12) months. If Part E is completed, I have elected to continue coverage due to the qualifying event indicated above and I understand that in order to retain my coverage continuation, I must meet the required payment obligations and/or other conditions as may be required.

Employee Signature: _____ **Date:** _____

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

Qualifying Event Number:

1 Employee Termination or Reduction of Work Hours	3 Employee Total Disability	5 Employee Eligible For Medicare
2 Employee Death	4 Divorce or Legal Separation	6 Dependent No Longer Eligible

Coverage Continuation Applies To:	Event Number	Date of Qualifying Event	Social Security Number
<input type="checkbox"/> Employee & All Dependents Currently Enrolled		/ /	
<input type="checkbox"/> Employee Only		/ /	
<input type="checkbox"/> Spouse Only		/ /	- -
<input type="checkbox"/> Dependent(s) Only – List Names in Part C		/ /	- -
<input type="checkbox"/> Employee & Spouse		/ /	
<input type="checkbox"/> Employee & Dependent Child(ren)–List Names in Part C		/ /	

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:

- Type or print clearly with a pen.
- 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

- Complete all sections for each dependent.
- Please read, sign and date form as verification of your change request.
- Return completed form to your benefit administrator.

PART E: COBRA – Complete this section only if an individual has selected continuation of coverage under COBRA.

- Select a *Coverage Type*, the appropriate *Qualifying Event Number*, *Date of Qualifying Event* and *Effective Date of Coverage*.
- If employee is not enrolling for COBRA, provide Social Security Number of individual who is being enrolled.
- If group has a separate COBRA subgroup, it must be provided in Part B.

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 9385
Minneapolis MN 55440-9385