Disabled Dependent 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

Dependent Child's First Name, Middle Initial, Last Name:	Gender ☐ M ☐ F	Date of Birth / /
Relationship to Employee:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Date Disability Occurred: / /

Does Dependent Child Permanently 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 Who Is 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 my employer to deduct any required contributions for this insurance from my earnings. 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. I understand all benefits are subject to conditions stated in the account agreement and Certificate of Coverage.

I authorize all 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 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 I am entitled to receive a copy of this authorization. I further understand that this authorization will remain 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** ____________________

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

Is Child Now Incapable Of Self-Support Because Of A Disability? ☐ Yes ☐ No	Disability Has Existed Continuously Prior To Age 19? ☐ Yes ☐ No	Expected Length of Disability (Prognosis - Estimate Months Or Years Disability Will Continue):

Reason or Nature Of Disability (Please Give As Much Detail As Practicable):

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:** ( )

◆ Retain Copy For Your Records◆