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|-------------|--|---------------|--|---------------------------|--|
| Group Name: | | Group Number: | | Requested Effective Date: | |
|-------------|--|---------------|--|---------------------------|--|

EMPLOYEE INFORMATION (all fields required)

| | | | |
|--|--|---|--|
| Reason for application: <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Re-Hire <input type="checkbox"/> Qualifying Event _____ Qualifying Event Date _____ <input type="checkbox"/> COBRA – Start Date _____ <input type="checkbox"/> Termination/Last Day Worked _____ | | Change: Dependent <input type="checkbox"/> Add <input type="checkbox"/> Remove (select one) Only list the dependent(s) to add or remove. If removing dependent select "Waive" for each product to term for the dependent(s) listed below. Status <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Other: _____ Change <input type="checkbox"/> Plan <input type="checkbox"/> Address <input type="checkbox"/> Name <input type="checkbox"/> Other: _____ | |
| Last Name: | | First Name: | |
| Social Security Number: | | MI: | |
| Date of Birth: | | Gender: <input type="checkbox"/> M <input type="checkbox"/> F | |
| Address: | | | |
| Phone Number: | | Email Address: | |
| Gross Annual Salary: | | Occupation: | |
| Date of Hire: | | Number of hours worked per week: | |
| Are you authorized to work and reside in the United States: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

DEPENDENT INFORMATION

| Relationship | Last Name, First Name, MI | Gender | Date of Birth (mm/dd/yyyy) |
|--------------|---------------------------|---|----------------------------|
| | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| | | <input type="checkbox"/> M <input type="checkbox"/> F | |

INSURED PRODUCT SELECTION

Select your coverage(s).

| | | | | |
|---------------|---|------------|--|--|
| DENTAL | <input type="checkbox"/> Copay <input type="checkbox"/> PPOMAC <input type="checkbox"/> PPOUCR/ Indemnity <input type="checkbox"/> Prime <input type="checkbox"/> Waive | Plan Code: | | Enroll <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) |
| VISION | <input type="checkbox"/> Fashion <input type="checkbox"/> Designer <input type="checkbox"/> Premier <input type="checkbox"/> Waive | Plan Code: | | Enroll <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) |

PREMIER PARTNER PRODUCT SELECTION

Select your plan(s).

| | | | |
|---|---|---|--|
| Healthiest You Telemedicine <input type="checkbox"/> EMP <input type="checkbox"/> FAM <input type="checkbox"/> Waive | InfoArmor Identity Protection <input type="checkbox"/> EMP <input type="checkbox"/> FAM <input type="checkbox"/> Waive | US Legal Services Legal Plans <input type="checkbox"/> EMP <input type="checkbox"/> FAM <input type="checkbox"/> Waive | Whisker Docs Pet Help Line <input type="checkbox"/> Enroll <input type="checkbox"/> Waive |
|---|---|---|--|

OTHER COVERAGE

If you will have other Dental coverage that SecureCare will NOT be replacing, please complete the following information.

| | | | |
|---|--|----------------------------|--|
| Insurance Company | | Policy Effective Date | |
| Policyholder Name | | Policyholder Date of Birth | |
| Of those to be covered under SecureCare Dental, who is also covered under the other Group Dental Insurance? | | | |
| <input type="checkbox"/> Employee <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other Dependent(s) | | | |

| | | | |
|----------------|--|-------------------|--|
| Employee Name: | | Group Name or ID: | |
|----------------|--|-------------------|--|

SECTION I: DECLARATION, AGREEMENT, ACKNOWLEDGEMENT

Declaration and Agreement – I have personally completed and reviewed all my answers to the questions in this Enrollment form and represent, to the best of my knowledge and belief, that all information I have provided is true, complete and correctly recorded. I understand that this information will be used to determine each proposed insured's eligibility for coverage under the Policy and any false statement or misrepresentation may result in loss of coverage or claim denial. The Employee (and Spouse/Domestic Partner or Dependent, if coverage elected) must be eligible based on the underwriting rules in effect on the date of enrollment and on the Certificate Date. Coverage (or change of coverage), if issued and approved by SecureCare, will become effective on the date recorded in the Certificate Schedule and not the date this Enrollment Form is signed. I understand that no agent or producer can accept risk, modify policies, or waive any rights or requirements of SecureCare. If this Enrollment Form is completed electronically, I agree that my electronic signature serves as my original signature.

Payroll Deduction -- I hereby request, authorize and direct my Employer to deduct the appropriate premium amount from my salary or wages, and any required premium thereafter, and forward that amount to SecureCare. This authorization will remain in effect until revoked by me in writing.

Arizona Fraud Warning: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Colorado Fraud Warning: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Nevada Fraud Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

THIS IS A LIMITED BENEFIT POLICY. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE OR COMPREHENSIVE MEDICAL BENEFIT PLAN AND IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. PLEASE REVIEW THE CERTIFICATE CAREFULLY.

A delayed effective date will apply if the employee is not Actively at Work or a dependent is in a period of limited activity on the date the insurance would otherwise take effect.

Employee signature

(Faxed signature bears the full authority of the original signature)

Date

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4547 N 7th St Suite 120
Phoenix, AZ 85014

Tel: (602) 241-0914
Toll Free: (888) 429-0914
Fax: (602) 285-0121
www.mysecurecare.com

Dental and Vision Underwritten by:
American National Life Insurance Company of Texas Galveston, Texas