



Dental • Vision • Life • Disability • Worksite

employer master group application

If any of the required items are missing or incomplete, processing of case may be delayed.

New Business Requirements

- ☐ Dental and/or Vision must be sold to offer additional Insured Products (Life, Short Term Disability, etc..) and Premier Partner plans.
- ☐ Salary information is required for Life and Short-Term Disability products.
- ☐ Copy of sold quote presented to employer with the coverage and plan selections indicated
- ☐ Signed Employer Master Group Application. Employer must be in business for at least 12 months.
- ☐ Complete the Producer Information section of the Employer Master Group Application.
- ☐ Employee Enrollment Form for each employee. Fill in Dates of Hire and SS#s.
- ☐ Waiver of coverage on the Employee Enrollment Form must be completed and signed by each employee not enrolling.
- ☐ Employer's binder check for the first month's premium + admin. fee. Please make checks payable to **SecureCare**.

Monthly Administration Fee

Monthly fee based on the number of employees enrolled in Dental. If no Dental coverage, then monthly fee is based on the number of employees enrolled in Vision. Monthly fee is subject to charge per the fees below as the number of employees and/or benefits change during the plan year. If neither dental or vision is enrolled after the initial effective date, then lowest admin. fee will be charged.

2-24 insureds - \$15.00/month

25-49 insureds - \$20.00/month

50 or more insureds - \$30.00/month

Replacement Benefits

Replacing another plan with a SecureCare plan

If replacing dental, submit a copy of the present carrier's summary of benefits or a complete policy. If current dental plan is a prepaid (DHMO) plan, please submit the current schedule of copays. • Current carrier's last monthly premium bill prior to your group's effective date with SecureCare. Include each employees' coverage effective date under the prior dental plan to receive take-over credit.

Please complete the Prior Coverage section if SecureCare plans are replacing other coverage.

Enrollment Reminder

For dental and vision coverage all existing employees (not subject to company waiting periods) who want coverage must enroll during Open Enrollment. If they do not, then these employees must wait until the next renewal/Open Enrollment to enroll. If employees choose to enroll at renewal, then we must receive their Enrollment Forms within 31 days of your group's renewal date.

Groups enrolling that are currently covered by SecureCare with a PEO will retain their current PEO premium rates during the first year.

For all new hires who want to enroll, we must receive their Enrollment Form within 31 days of the date they become eligible for benefits. New hires become eligible first of the month following any group waiting period your company has in place.

Submitting Enrollment Materials & First Premium Payment

Please submit enrollment materials and binder check to:

SecureCare
4745 N 7th Street Suite 120
Phoenix, Arizona 85014

Employer Group Information

Legal Name of Employer: _____

Physical Address (primary location): _____

Mailing Address (if different from above): _____

State of Employer's Principal Place of Business: * _____

*Unless otherwise governed by ERISA, this state's laws shall govern the policy.

Nature of Business: _____ SIC Code: _____

Federal Tax ID: _____ Year operations began: _____

Business is organized as (Select One): ☐ Corporation ☐ Partnership ☐ LLC ☐ Union ☐ Other _____What is your payroll frequency? ☐ Weekly ☐ Bi-Weekly ☐ Semi-monthly ☐ Monthly ☐ Other: _____Monthly Bill by Division: On your monthly premium bill would you like employees listed by company division? ☐ Yes ☐ No

If Yes, list Divisions: _____

Do you currently have comprehensive major medical coverage that meets the minimum coverage standards under the Affordable Care ACT

☐ Yes ☐ NoAre you covering Domestic Partners? ☐ Yes ☐ No**Contact information**

Benefits: Name: _____ Phone Number: _____

Email: _____

Billing: Name: _____ Phone Number: _____

Email: _____

Affiliate and/or Subsidiary InformationEmployees will be insured under the policy **only** if the affiliate or subsidiary is identified below.

Name	Address (if different)	Nature of business	% Owned by Applicant
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Eligibility Information**New Employee Waiting Periods** - Employee's coverage will be effective first of month following completion of selected waiting period.**Class 1:** _____ ☐ 30 days ☐ 60 days ☐ 90 days ☐ Date employed ☐ Other _____**Class 2:** _____ ☐ 30 days ☐ 60 days ☐ 90 days ☐ Date employed ☐ Other _____**Class 3:** _____ ☐ 30 days ☐ 60 days ☐ 90 days ☐ Date employed ☐ Other _____**Full-time time eligibility:** Employees must be full-time and actively at work for coverage. Full-time is a minimum of 30 hours.

How many full-time, eligible employees do you have, including owners? _____ For employer sponsored dental and vision plans at least 75% of eligible EEs must enroll. To offer 2 or 3 dental plans, at least 5 eligible EEs must enroll.

Insurance Coverage & Premium Contribution

Effective Date _____

Attach sold quote(s) with specific coverage selections. The following Group Insurance is applied for as specified in the sold case quote(s). Please check boxes below for Group Insurance selected.

If employer pays 100% of the employee premium, then all eligible employees must enroll

Select Coverage(s) to Add	Dental	Vision	Accident
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employer will pay the percentage(s) below toward the employee premium for the plans selected. Please fill in percentage(s) below.			
	%	%	%

Premier Partners & Employer Contribution

Please check Premier Partner Plans sold and fill in employer contribution percentages.

Add Plan(s)	<input type="checkbox"/> Healthiest You Telemedicine	<input type="checkbox"/> InfoArmor ID Security	<input type="checkbox"/> LegalEase Legal Plans	<input type="checkbox"/> WhiskerDocs Pet Help Line
Employer Contribution %	Family %	Employee % Family %	Family %	Family %

Prior Coverage

Will coverages selected replace existing insurance? ☐ Yes ☐ No If yes, please list the prior carrier(s).

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Prior Plan Termination Date

Concurrent Dental Coverage

Are you offering another Dental plan along with SecureCare? ☐ Yes ☐ No

If yes, type of plan: ☐ DMO ☐ PPO ☐ Indemnity

If yes, list the name of the other plan: _____ Number of EEs covered under plan: _____

Employer Agreement

The policy applied for will not be effective until formal approval is given by SecureCare.

Declaration and Agreement The employer hereby applies to SecureCare for a group policy. The employer represents that all answers contained herein are true and complete and form the basis of the group policy. Any material misstatements or failure to report information may result in revision to the terms and conditions or may cause rescission or termination of the Policy for Employer and Covered Persons. Coverage will not become effective under the Policy until written approval is received from the SecureCare and the required premium is paid. SecureCare may decline acceptance of the request for coverage of any person for whom coverage is requested. No agent or producer can accept risks, modify policies, or waive any rights or requirements of SecureCare.

Acknowledgement Employer understands that if applying for an Accident, Limited Medical or FlexCare Policy, that these insurance Policies are supplemental and provide limited benefits and are not major medical or comprehensive medical benefit plans and are not substitutes for such coverage. The policies are limited and are not designed to cover all medical expenses. The employer understands that no Accident, Limited Medical and FlexCare Policy benefits are payable for sickness during the first 30 days following a Certificate Coverage Effective Date, if sickness is included and that pre-existing conditions are excluded for 12 months.

If applying for Critical Illness coverage, employer understands that coverage applied for provides lump sum payments only for Critical Illness listed. The policy does not provide for reimbursement of any medical expenses. Benefits provided are a supplement, and not intended as a substitute for medical expense coverage or disability insurance.

Lack of major medical coverage (or other minimum essential coverage) may result in additional payment with your taxes. Please review the policy carefully.

Premiums Premium rates quoted for Dental, Vision, Group Life, Accident, Short Term Disability, Limited Medical, FlexCare and Critical Illness were based on the data submitted to SecureCare. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured. The employer agrees to timely remit the total premiums due to SecureCare in accordance with the terms of the policy.

Important Information SecureCare reserves the right to review the applicant's payroll/wage & tax records at any time to confirm eligibility. SecureCare may request the applicant's most recent wage & tax payroll records. The applicant agrees to furnish SecureCare with all information and documentation which may be responsibly required with regard to eligibility.

By signing this form, I hereby certify, as a condition of eligibility, that the Group is in compliance with the minimum participation requirements as expressed in the group policy. SecureCare reserves the right to request and review payroll or other documentation confirming compliance. I represent that the information I have provided is accurate and truthful. I understand that any intentional misrepresentation of material fact or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums retroactive to the policy date, or other consequences as permitted by law.

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.

BY:

Owner's or Officer's Signature

Date

Owner's or Officer's Name and Title Printed

Producer Information

Are you currently licensed in the state in which you solicited this application? ☐ Yes ☐ No

Are you currently appointed with AMERICAN NATIONAL INSURANCE COMPANY OF TEXAS? ☐ Yes ☐ No

Are you currently appointed with STANDARD LIFE AND ACCIDENT INSURANCE COMPANY? ☐ Yes ☐ No

Do you carry an Errors and Omissions Policy? ☐ Yes ☐ No If yes, who is the carrier? _____

Producer Name: _____

Agency/Corp. Name: _____

Agency Address: _____

Producer Fed Tax ID: _____

Make commission payable directly to: ☐ Agency (listed above) ☐ Producer (listed above) ☐ General Agency (listed below)

General Agent (GA) Name: _____

General Agency Name: _____

General Agency Address: _____

General Agent Fed Tax ID: _____

GA commission payable to: _____

(TAX INFORMATION FORM IS REQUIRED FROM ALL AGENTS & GENERAL AGENTS)

AGENT STATEMENT: I hereby certify that all the information contained in the Agreement and Application is correct to the best of my knowledge, and I know of nothing unfavorable about this firm or any individual proposed for coverage. I have complied with the underwriting rules and regulations and have explained in detail the coverage to the new group and its employees.

Signature of Producer

Date

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

Life, Short Term Disability and Accident Underwritten by
Standard Life and Accident Insurance Company
Galveston, Texas

SecureCare Group Insurance
4745 N 7th Street Suite 120
Phoenix, Arizona 85014

Tel: 602.241.0914
Toll free 888.429.0914
Fax: 602.285.0121
www.mysecurecare.com