SECURECARE
GROUP INSURANCE

ENROLLMENT/COVERAGE CHANGE FORM

Group Name:	Group Number:	Requested Effective Date:

EMPLOYEE INFORMATION (all fields required)

Reason for application:
☐ New Hire ☐ Open Enrollment
☐ Qualifying Event _____
Qualifying Event Date _____
☐ COBRA – Start Date _____

Change:
Dependent ☐ Add ☐ Remove (select one)
Only list dependent(s) to add or remove. If Removing Dependent select "Waive" below for product(s) to term for dependent(s) listed.

Change ☐ Plan ☐ Address ☐ Name ☐ Other:

☐ Termination (**Last Day Worked required if leaving company)**

Last Name	First Name	MI	**Social Security Number (required)**

Address 1	Apt/Suite #	City	State	Zip Code

Gender ☐ M ☐ F	Date of Birth	Best Contact Phone #	**Date of Hire (REQUIRED)**:	Class

Email Address:	Division:

DEPENDENT INFORMATION

Relationship	SSN	Last Name, First Name, MI	Gender	Date of Birth (mm/dd/yyyy)
Spouse			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	

INSURED PRODUCT SELECTION

Select your Plan Type and Enrollees

Dental	☐ Copay ☐ PPO MAC ☐ PPO UCR/Indemnity ☐ Prime ☐ Waive	Plan Code:		Enroll: ☐ Spouse ☐ Child(ren)
Vision	☐ Fashion ☐ Designer ☐ Premier ☐ Waive	Plan Code:		Enroll: ☐ Spouse ☐ Child(ren)

PREMIER PARTNER PRODUCT SELECTION

Select your plan(s)

Healthiest You Telemedicine	**InfoArmor** Identity Protection	**LegalEase** Legal Plans
☐ EMP ☐ FAM ☐ Waive	☐ EMP ☐ FAM ☐ Waive	☐ EMP ☐ FAM ☐ 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?
☐ Employee ☐ Spouse ☐ Child(ren)

SECURECARE
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Employee Name:	Group Name or ID:

DECLARATION, AGREEMENT, ACKNOWLEDGEMENT

Declaration and Agreement – I hereby apply for coverage as indicated. I hereby authorize any physician, dentist, eye care professional, hospital or insurer having any records or information concerning health history or other insurance on me, or my minor dependents, to furnish such records, data or information as may be requested by the insurer or their duly authorized representative to determine benefits, if any, and/or process claims. I understand that this authorization is valid for a minimum of 12 consecutive months from the date signed. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I, or any authorized representative, may receive, upon request, a copy of this authorization. **It is the employee's responsibility to notify the administrator, Southwest Preferred Dental Organization, of any changes of address or family status in writing by completing a new enrollment form.**

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.

Texas Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Utah Fraud Warning: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison.

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

Date

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

Administered by:
Southwest Preferred Dental Organization
777 E Missouri Ave Ste 121 * Phoenix, AZ 85014
Tel: (602) 241-0914 * Toll Free: (888) 429-0914
Email: group@securecaredental.com * Fax: (602) 285-0121
www.securecaredental.com