



# Membership Enrollment Form

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**INSTRUCTIONS PROVIDED ON BACK**

**PART A – EMPLOYEE INFORMATION**

<b>Employee's Name:</b>	Last	First	Middle Initial	<b>Social Security Number</b> / /
<b>Gender:</b>	Male <input type="checkbox"/>	Female <input type="checkbox"/>	<b>Marital Status:</b>	<b>Date of Birth (Month-Day-Year)</b> / /
		Single <input type="checkbox"/>	Married <input type="checkbox"/>	
		Widowed <input type="checkbox"/>	Divorced <input type="checkbox"/>	
			Legally Separated <input type="checkbox"/>	
<b>Employee's Address:</b>	Address		Home Phone Number	Work Phone Number
	City	State	Zip Code	

**PART B – ENROLLMENT INFORMATION**

<b>Select Coverage Type (Check One Box Only):</b>	<b>Complete If Multiple Plan Options Are Offered</b>
<input type="checkbox"/> Employee Only*	I elect to participate in the following Plan: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input checked="" type="checkbox"/> Plan C <input type="checkbox"/> Plan D
<input type="checkbox"/> Employee and Spouse	
<input type="checkbox"/> Employee and Dependent Child(ren)	
<input type="checkbox"/> Family	
<input type="checkbox"/> No Coverage*	
<b>* If waiving coverage for employee and/or any eligible family members, you must complete Part D.</b>	

**PART C – DEPENDENT INFORMATION**

Relationship To Employee	First Name, Middle Initial, Last Name <small>(Include Last Name Only if Different From Employee's)</small>	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 – WAIVE COVERAGE**

Do you (the employee) have other dental coverage?  Yes  No    Do your dependents have other dental coverage?  Yes  No

Name of Carrier: \_\_\_\_\_ Policy/Identification Number: \_\_\_\_\_

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Securian Dental reserves the right to decline any further enrollment changes.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PART E – EMPLOYEE SIGNATURE**

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. 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 may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER**

<input checked="" type="checkbox"/> <b>New Group</b> Hire Date: _____ Effective Date: <u>08 / 01 / 2008</u>	<input type="checkbox"/> <b>Rehire</b> Date Lay Off Began: _____ Date Rehired: _____
<input type="checkbox"/> <b>Existing Securian Dental Group Changing Plan</b> Hire Date: _____ Prior Coverage Start Date (if applicable): _____ Effective Date: _____	<input type="checkbox"/> <b>Return from Leave of Absence</b> Date Leave Began: _____ Date Returned to Work: _____
<input type="checkbox"/> <b>Open Enrollment</b> Coverage Effective Date: _____	<input type="checkbox"/> <b>Employee Change Part Time to Full Time</b> Date of Status Change: _____ Effective Date: _____
<input type="checkbox"/> <b>New Hire – Apply Probationary Period (if applicable) to determine Coverage Effective Date</b> Hire Date: _____ Effective Date: _____	<input type="checkbox"/> <b>Loss of Coverage – Employee and/or Dependent</b> Hire Date: _____ Date of Loss: _____ Effective Date: _____
	<input type="checkbox"/> <b>Previously Waived Coverage – Qualifying</b> Event Reason: _____ Hire Date: _____ Event Date: _____ Effective Date: _____
<b>Group Name:</b> Southern Design Services <b>Group &amp; Subgroup Numbers:</b>	
<b>Group Representative's Signature:</b> _____ <b>Date:</b> _____ <b>Phone Number:</b> ( ) _____	