EMPLOYER MASTER GROUP APPLICATION

AND GROUP ENROLLMENT CHECKLIST

SECURECARE

GROUP INSURANCE

Dental ▪ Vision

TRIPLE CHOICE PLANS™

by SecureCare Dental

MORE REASONS TO SMILE

GROUP ENROLLMENT CHECKLIST

I.D. CARDS AND POLICIES WILL BE ISSUED **ONLY** WHEN CHECKLIST IS COMPLETE.

I. NEW BUSINESS REQUIREMENTS (Please check the boxes below as each is completed.)

- ❑ Employer Master Group Application (signed by owner or officer of the employer group)
- ❑ (For Agent) Be sure to complete the Producer/General Agent Information portion on the back of the Employer Master Group Application.
- ❑ Employee Enrollment Form for each employee. (**Make sure dates of hire and SS#'s are filled in.)**
- ❑ **(For Employer Sponsored Plans Only)** Waiver of Coverage portion of the Employee Enrollment Form must be completed and signed by each employee not enrolling.
- ❑ **(For Employer Sponsored Plans Only)** Copy of employer's most recent state and quarterly unemployment tax report. Please indicate current status of each employee (number of hours worked, date of termination, if no longer employed, or if considered seasonal). **Employer must be in business for at least 12 months.**
- ❑ Employer's check for the first month's premium. Please make checks payable to ***SECURECARE DENTAL*. Please include the monthly administration fee in the check**. The fees are:

  Groups with 2-24 insureds……..$15.00/month
  Groups with 25-49 insureds……$20.00/month
  Groups with 50 insureds or more……...$30.00/month
  PEOs (Employee leasing companies)…….$50.00/month

II. FOR REPLACEMENT BENEFITS (replacing another plan with *SECURECARE DENTAL* & *VISION*)

- ❑ Submit a copy of the present carrier's summary of benefits or a complete policy. If current dental plan is a prepaid (HMO) plan, please submit the current schedule of copays.
- ❑ Present carrier's last monthly premium bill prior to your group's effective date with SecureCare Dental & Vision
- ❑ Include each employee's coverage **effective date** under the prior dental plan to receive take-over credit.

III. ENROLLMENT REMINDER

1. 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 renewal 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.
2. Groups enrolling that are currently covered by SecureCare Dental & Vision through a PEO will retain their current PEO premium rates during the first year.
3. 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 following any group waiting period your company has in place.

IV. PLEASE SUBMIT ENROLLMENT MATERIALS TO:

SecureCare Dental
777 East Missouri Ave., Suite 121
Phoenix, Arizona 85014

www.securecaredental.com

EMPLOYER MASTER GROUP APPLICATION

THE EMPLOYER CERTIFIES THE FOLLOWING INFORMATION

Company's Legal Name:_____
(Also note how you would like Company Name to appear on your SecureCare Dental & Vision Plan Materials, (ie I.D. cards)

Benefits Contact Name: _____ Contact's e-mail address _____

Billing Contact Name: _____ Contact's e-mail address _____

Street Address:_____
Street City State Zip

Mailing Address: _____
Street City State Zip

Billing Address: _____
Street City State Zip

Telephone Number (_____) _____ Fax Number (_____) _____

Year Started _____ (must be in business 12 months) Tax ID#: _____ Nature of Business _____

Other subsidiaries/affiliates/locations to be insured (may use back) Complete Address # of Employees

_____ _____ _____

_____ _____ _____

SECURECARE DENTAL INSURANCE: List Quote ID and Plan Code(s) for your dental coverage. Dental quote must be attached.

Quote ID:		Plan Code 1:		Plan Code 2:		Plan Code 3:	

	Employer-Sponsored	Employer-Sponsored or Voluntary Dental: Please select only one. (Employer-sponsored plans are available only for groups of 5 or more employees.)
	Voluntary	

	Number of Employees Enrolling for Dental Insurance

SECURECARE VISION INSURANCE: List Quote ID, if different than Dental. Check box next to plan selected. Vision quote must be attached.

Quote ID:		**Fashion**	☐	**Designer**	☐	**Premier**	☐

	Employer-Sponsored	Employer-Sponsored or Voluntary Vision: Please select only one. Insured vision plans are available only for groups enrolling 5 or more employees.)
	Voluntary	

	Number of Employees Enrolling for Vision Insurance

	SECUREONE VISION Discount Plan **(Includes Vision, Dental, Hearing, Chiropractic and Pharmacy)** If offering SecureOne Plan, please check box. **This is not insurance. These services are non-insured. Available for 2 or more enrolled**

COVERAGE EFFECTIVE DATE: _____ **EMPLOYER CONTRIBUTION: DENTAL: EE ____% Dep ____%**
VISION: EE ____% Dep ____%

NEW EMPLOYEE WAITING PERIOD: (Employee's coverage will be effective first of month following completion of waiting period.)
Class I: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Date Employed ☐ Other: _____
Class II: ☐ 30 days ☐ 60 days ☐ 90 days ☐ Date Employed ☐ Other: _____

DOMESTIC PARTNER: Are you covering Domestic Partners? ☐ **YES** ☐ **NO**

FULL-TIME ELIGIBILITY: Employees must be full time for coverage. Full time is a minimum of 30 hour/week.

PARTICIPATION: How many full-time (working 30 or more hours per week) employees do you have, including owners? _____
For employer sponsored plans at least 75% of eligible EEs must enroll. To offer 2 or 3 dental plans, at least 5 eligible EEs must enroll.

COVERAGE REPLACEMENT BENEFITS: Is this Plan intended to replace existing dental coverage? ☐ YES ☐ NO
If yes, to be eligible to receive replacement benefits (if any), then you must complete the items listed in Part II of Group Enrollment Checklist. Indicate date coverage will terminate and insurer's name: _____

CONCURRENT DENTAL COVERAGE: Are you offering SecureCare Dental along with another dental plan? ☐ YES ☐ NO

If yes, name of other plan:______________________________

Type of Plan: ☐ DMO ☐ PPO ☐ Indemnity Number of eligible employees covered under the plan:__________

MONTHLY ADMINISTRATION FEE **(Based on the number of insured employees. Fee is waived for vision if dental and vision are bundled)** (Fee is subject to change per the fees below as the number of insured employees changes.)
2-24 insureds - $15.00/month • 25-49 insureds - $20.00/month • 50 insureds or more - $30.00/month • PEOs - $50.00/month

I have read the application and agree to abide by the terms and conditions herein. I understand that (1) only the Insurer or its authorized administrator can approve this application or establish an effective date, and (2) only the Insurer can waive or alter any provisions of this application or the policy.

I also certify that all employees enrolling under this contract are eligible for benefits under the respective policy.

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.

BY: ______________________________ Date: ____________________

(OWNER OR OFFICER'S SIGNATURE)

____

(OWNERS OR OFFICER'S NAME AND TITLE PRINTED)

PRODUCER INFORMATION:

1. Are you currently licensed in the state in which you solicited this application? ☐ YES ☐ NO
2. Are you currently appointed with AMERICAN NATIONAL INSURANCE COMPANY OF TEXAS? ☐ YES ☐ NO
3. Do you carry an Errors and Omissions Policy? ☐ YES ☐ NO If yes, who is the carrier? ____________________

Agency Name:______________________________ Agent Name: ____________________

SecureCare Dental & Vision should make broker/agency commission payable directly to (please check one):

☐ Agency (listed above) ☐ Agent (listed above) ☐ General Agency (listed below)

Broker/Agent Mailing Address: ______________________________

Street City State Zip

Business Phone: (______) ______________ Fax # (______) ______________ Home Phone: (______) ________

Broker/Agent Federal Tax ID Number ____________________

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General Agency Name: ______________________________General Agent Name: ____________________

Make General Agent commission checks payable to: ______________________________

Check Mailing Address: ______________________________

Street City State Zip

Business Phone: (______) ______________ Fax # (______) __________ Home Phone: (_____) ______________

(TAX INFOMATION 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 Agent______________________________ Date ______________

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

SecureCare Dental
777 East Missouri Ave., Suite 121
Phoenix, Arizona 85014

Tel: (602) 241-0914 Toll free 1-888-429-0914
Fax: (602) 285-0121
www.securecaredental.com