

ENROLLMENT / COVERAGE CHANGE FORM

NOTE: Employee must initial by all changes to the Enrollment Form.

SECTION 1: ENROLLMENT/COVERAGE CHANGE (Please Select)

NEW ENROLLMENT **Plan Change (Complete entire form.)** **Address/Name/Phone Change**

Add **OR** Delete Dependent(s) (Complete Sections 3, 4, 5, 6, 7, 8 & 10) Reason: Employment Status Qualifying Event
Please state Qualifying Event: _____ Date of Status Change/Event: ____/____/____

COBRA Continuation **Termination - Last Day Worked:** ____/____/____ (Complete Sections 3 & 10)
Reason: Left Employment Reduced Hours Other Insurance _____

SECTION 2: WAIVING COVERAGE I Do Not Want Dental Vision Coverage (Complete Sections 3, 10) Reason for Waiver: _____

SECTION 3: EMPLOYEE INFORMATION (Please PRINT Clearly)

Social Security #	Last Name			First Name	M. I.
Street Address (mailing)	City	St	Zip		
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (mm/dd/yyyy) / /	Employer Name	Email address		
Position / Division	Date of Hire (Full-Time) (REQUIRED) / /	Work Telephone			

SECTION 4: DENTAL PLAN OPTIONS The Copay Plan PPO MAC Plan PPO UCR or Indemnity Plan Plan Code: _____

SECTION 5: VISION PLAN OPTIONS SecureCare Vision (insured) Fashion Plan Designer Plan Premier Plan

SECTION 6: HEALTHIEST YOU Are you enrolling? Yes No (24 x 7 Telemed, Prescription savings, Procedure cost compare)

SECTION 7: INFOARMOR Are you enrolling? Yes, employee only Yes, employee and family No

SECTION 8: DEPENDENT INFORMATION

Last Name (if different), First Name, Middle Initial	DOB	M/F	SS#	Dental Plan		Vision Plan	
				Add	Delete	Add	Delete
Spouse/Domestic Partner							
Child							
Child							
Child							

SECTION 9: OTHER INSURANCE COVERAGE THAT SECURECARE DENTAL IS NOT REPLACING

Will you have concurrent coverage with other group dental insurance that SecureCare Dental is not replacing?
 Yes – Complete this section. NO– Skip to Section 8.

Insurance Co. Name	Insurance Co. Phone Number:
Name of Policyholder	Policyholder's Soc.Security #
Employee Name	Policyholder's Date of Birth:
	Effective Date of Coverage:

Of those to be covered by SecureCare Dental, who is also covered under the other group dental insurance?
Check all that apply: Self Spouse Children

SECTION 10: AUTHORIZATION

I hereby apply for insurance coverage, and authorize my employer/union to deduct from my earnings the necessary contribution, if any, that is required of me. I hereby authorize any physician, dentist, eye care professional, hospital, or insurer having any records or information concerning health history or other insurance for 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. **NOTE: 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 form.**

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.

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

Date Signed _____

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

Administered By: **Southwest Preferred Dental Organization**
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