SECURECARE
GROUP INSURANCE
Dental • Vision

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: ☐ Female ☐ 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 Plan MAC** ☐ **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, I am not**

SECTION 8: DEPENDENT INFORMATION

				Dental Plan		Vision Plan	
Last Name (if different), First Name, Middle Initial	**DOB**	**M/F**	**SS#**	**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.**

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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