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

Change:
Dependent ☐ Add ☐ Remove (select one)
Only list the dependent(s) to add or remove. If removing dependent select "Waive" for each product to term for the dependent(s) listed below.
Change ☐ Plan ☐ Address ☐ Name ☐ Other:

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

Address	Apt/Suite #	City	State	Zip Code

Gender	Date of Birth	Best Contact Phone #:	**Date of Hire (REQUIRED)**	Height (ft in)		Weight
☐ M ☐ F	/ /	( ) -	/ /			

Email Address:	Class:

*Gross Annual Salary	**Occupation:	Division:

***Salary is required for LIFE coverage. **Salary and Occupation are required for Short Term Disability coverage.**

All applicants must sign and date the Declaration on Page 5.

DEPENDENT INFORMATION

Relationship	SSN	Last Name, First Name, MI	Gender	Date of Birth (mm/dd/yyyy)	Height (ft. in.)	Weight (lbs.)
Spouse			☐M ☐F	/ /		
			☐M ☐F	/ /		
			☐M ☐F	/ /		
			☐M ☐F	/ /		
			☐M ☐F	/ /		
			☐M ☐F	/ /		

INSURED PRODUCT SELECTION

Select your coverage(s).

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)

	Basic Term Life & Amount	Supplemental OR Voluntary Term Life & Amount	Short Term Disability	Accident
Employee	☐ $	☐ $	☐ $	☐
Spouse		☐ $		☐
Child(ren)		☐ $		☐
Plan Code				
Waive	☐	☐	☐	☐

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

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Employee Name:		Group Name or ID:	

OTHER COVERAGE FOR DENTAL

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)

REPLACEMENT COVERAGE

List replacement/concurrent coverage(s).

List prior coverage(s) that are being replaced or that you are keeping. If any proposed insured has other Short Term Disability coverage that will be kept, include the name of the proposed insured and the monthly benefit from the prior coverage in the Other Information column.

Product	**Insurance Company Name**	**Prior Plan Effective Date**	**Prior Plan Termination Date**	**Other Information**
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

BENEFICIARIES

Attach another sheet if more space is needed.

Product	**Type**	**Name**	**Relationship**	**Date of Birth MM/DD/YYYY**	**Social Security Number** (optional)
	Primary				
	Contingent				
	Primary				
	Contingent				
	Primary				
	Contingent				

SECTION A: LIFE - GENERAL QUESTIONS (Simplified Issue or Late Entrant)

A1. Has any proposed insured used tobacco in any form during the last 12 months? ☐ Yes ☐ No

Name(s):

A2. **If applying for dependent Life coverage**, are all proposed dependents in good health and able to perform the activities of a person of like age and gender] [has any proposed dependent missed 5 consecutive days of normal activity due to illness or injury during the last 3 months? If No, list name(s) to be excluded from coverage. Answer questions A3 – A5 for those proposed insureds that are in good health. ☐ Yes ☐ No

Name(s):

A3. Has any proposed insured been diagnosed by a physician with, been tested positive for, or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? If Yes, list name(s). ☐ Yes ☐ No

Name(s):

A4. Has any proposed insured been informed by a physician of any abnormal test results or been advised to have any diagnostic/screening tests or procedures, which have not been performed? If Yes, list name(s). ☐ Yes ☐ No

Name(s):

A5. Within the last 10 years, has any proposed insured been diagnosed with, or had any indication of, or symptom of, or had treatment for, or been recommended to have treatment for heart, brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, digestive, neurological, rheumatoid, other major organ disorders, or insulin dependent diabetes, Amyotrophic Lateral Sclerosis (ALS), drug abuse, alcoholism, cancer or malignancy in any form (except non-melanoma skin cancer)? ☐ Yes ☐ No

If Yes, provide details in the Health Details Section. Include all dates, names/addresses of hospitals and all physicians, nature of the condition/impairment, the treatment or advice given and if released from treatment.

If you answer any medical questions for Life or Short-Term Disability coverage, you are required sign and date the Medical Release of Information on page 4.

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SECTION B: SHORT TERM DISABILITY - MEDICAL QUESTIONS (Simplified Issue or Late Entrant)

B1. Has any proposed insured been diagnosed by a physician as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex) verified by prior FDA approved tests consisting of both a positive screening test and a positive supplement test (enzyme-linked immunoassay (ELISA) and Western Blot)? ☐ Yes ☐ No

B2. Within the past 2 years, has any proposed insured been convicted of a DWI, DUI or OUI? If Yes, also answer question B6. ☐ Yes ☐ No

B3. Within the past 6 months, has any proposed insured been hospitalized or missed more than 5 consecutive days of work due to sickness or injury other than cold, flu or normal pregnancy? If Yes, also answer question B5. ☐ Yes ☐ No

B4. Within the past 6 months, has any proposed insured received medical advice or treatment or has treatment been recommended by any doctor, or taken any prescription medication for heart disease, cancer (except non-melanoma skin cancer), stroke, COPD, liver disease, organ failure, organ transplant, dementia, Alzheimer's, psychosis or major depression? If Yes, provide details in the Health Details Section and you MUST answer question B5 (next page). ☐ Yes ☐ No

B5. Within the past 5 years, has any proposed insured received medical advice or sought treatment (including medication) or has treatment been recommended for: heart disease, heart attack, congestive heart failure, heart surgery, stroke, transient ischemic attack, AMS, leukemia, Hodgkin's disease, multiple sclerosis, muscular dystrophy, major depression, bipolar disorder, psychosis, dementia, Alzheimer's neurological disorders, lupus erythematosus, connective tissue disorder, organ failure, ulcerative colitis, Crohn's disease, COPD, lung disease, liver disease, insulin dependent diabetes, cancer (except non-melanoma skin cancer), reproductive disorders, kidney or renal disease (except stones), arthritis, bone, joint or muscular illness or injury? If Yes, provide details in the Health Details Section. ☐ Yes ☐ No

SECTION G: HEALTH DETAILS SECTION

Proposed Insured	Question #	Date(s) of Treatment Begin	End	Condition, Injury, Diagnosis, Medication	Treatment, Results, Degree of Recovery	Name/Address of Physicians (street, city, state)

If you answer any medical questions for Life or Short-Term Disability coverage, you are required sign and date the Medical Release of Information on page 4.

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Only sign and date this page if you filled out Medical Questions for Life or Short-Term Disability coverage.

Employee Name:		Group Name or ID:	

SECTION J: AUTHORIZATION TO OBTAIN, RELEASE AND DISCLOSE MEDICAL INFORMATION

I hereby authorize any: medical practitioner, hospital, clinic or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, pharmacy benefit manager, government agency, group policyholder, employer, benefit plan administrator, the MIB, Inc, the Department of Motor Vehicle Registration, and paramedical facility to provide to SecureCare, or any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on SecureCare's or its reinsures' behalf, information concerning advice, are or treatment sought by or provide to me and/or any other proposed insured for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, and/or drug , alcohol or tobacco usage of the applicant or any proposed insured. It is understood that SecureCare and Standard Life and Accident Insurance Company underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to be aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may redisclose it, resulting in loss of protection by federal regulations.

I understand that:

1. Such information will be used by SecureCare and Standard life and Accident Insurance Company for underwriting and insurability determinations;
2. I may refuse to sign this authorization and that my/our refusal to sign will affect my/our ability to obtain health insurance coverage;
3. A picture copy or photocopy of this authorization shall be as valid as the original; and
4. I am entitled to receive a copy of this authorization request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Health Underwriting Department of Standard life and Accident Insurance Company, PO Box 1991, Galveston, TX 77553. *I may inspect or copy any information used or disclosed under this authorization, if signed.*

Employee signature **Date**

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

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

Life, Short Term Disability, Accident, Cancer, Critical Illness, Limited Medical and FlexCare Underwritten by:
Standard Life and Accident Insurance Company
Galveston, Texas
888.350.1488

SecureCare
777 E Missouri Ave Ste 121
Phoenix, AZ 85014

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

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SECTION I: DECLARATION, AGREEMENT, ACKNOWLEDGEMENT

Declaration and Agreement – I have personally completed and reviewed all my answers to the questions in this Enrollment form and represent, to the best of my knowledge and belief, that all information I have provided is true, complete and correctly recorded. I understand that this information will be used to determine each proposed insured's eligibility for coverage under the Policy and any false statement or misrepresentation may result in loss of coverage or claim denial. The Employee (and Spouse or Dependent, if coverage elected) must be eligible based on the underwriting rules in effect on the date of enrollment and on the Certificate Date. Coverage (or change of coverage), if issued and approved by SecureCare, will become effective on the date recorded in the Certificate Schedule and not the date this Enrollment Form is signed. I understand that no agent or producer can accept risk, modify policies, or waive any rights or requirements of SecureCare. If this Enrollment Form is completed electronically, I agree that my electronic signature serves as my original signature.

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.

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 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.

THIS IS A LIMITED BENEFIT POLICY. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUE FOR MAJOR MEDICAL COVERAGE OR COMPREHENSIVE MEDICAL BENEFIT PLAN AND IS NOT DESIGNED TO COVER ALL MEDICAL EXPENSES. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. PLEASE REVIEW THE CERTIFICATE CAREFULLY.

Short Term Disability Acknowledgement –I understand that pre-existing conditions are excluded for the first 12 months after the Certificate Effective Date of each covered person unless the pre-existing condition limitation is waived.

A delayed effective date will apply if the employee is not Actively at Work or a dependent is in a period of limited activity on the date the insurance would otherwise take effect.

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

Date

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Galveston, Texas

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