EMPLOYER MASTER GROUP APPLICATION

AND GROUP ENROLLMENT CHECKLIST

SECURECARE DENTAL

GROUP INSURANCE

TRIPLE CHOICE PLANS™

PPO COPAY INDEMNITY

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.
- ❑ 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 0-24 insureds……...$10.00/month
  Groups with 25-49 insureds……$15.00/month
  Groups with 50 insureds or more……...$25.00/month
  PEOs (Employee leasing companies)……$50.00/month

II. FOR REPLACEMENT BENEFITS (If replacing another plan with SecureCare Dental)

- ❑ Submit a copy of the present carrier's summary of benefits or a complete policy. If current 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.
- ❑ Include each employee's **effective date** of coverage under the prior plan to receive complete 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 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
3625 North 16th Street, Suite 206
Phoenix, Arizona 85016

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 Plan Materials such as 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

_____ _____ _____

_____ _____ _____

	2-4		5 or More	**NUMBER OF EMPLOYEES ENROLLING: Please select only one.**

	Employer-Sponsored	**EMPLOYER-SPONSORED OR VOLUNTARY: Please select only one.** Employer-sponsored plans are available only for groups of 5 or more employees.
	Voluntary	

PREMIUM RATE STEPS: Please check only one.					
	Two Tier	Employee	Employee & Family		
	Three Tier	Employee	Employee & One Dependent	Employee & Family	
	Four Tier	Employee	Employee & Spouse	Employee & Child(ren)	Employee & Family

PLAN OPTIONS: Please select plan(s) and fill in your coverage.
SecureFlex is available only for groups enrolling 25 or more employees, and may only be offered with The Copay Plan.

	The Copay Plan		The PPO Plan		The SecureFlex Plan		The Indemnity Plan
Plan:____ (List plan number.)		____% 80% ____% 60% ____% 40%		100% 100% ____% 80% 80% ____% 50% 50% ____%		100% 100% 80% 80% 50% 50%

	Type II	**ENDODONTICS & PERIODONTICS: Please select only one.** Applicable on PPO, SecureFlex and Indemnity Plans. Type II is for employer-sponsored groups of 5 or more insured employees, and voluntary groups of 100 or more insured.
	Type III	

CALENDAR YEAR MAXIMUM: Please select only one. ($2,000 maximum for 5 or more groups.)					
	$1,000 Calendar Year Maximum		$1,500 Calendar Year Maximum		$2,000 Calendar Year Maximum
CALENDAR YEAR DEDUCTIBLE: Please select only one. (2-4 groups may select $50/$150 only)					
	$50/$150 per person/family		$75/$225 per person/family		$100/$300 per person/family

	85th Percentile	**NON-NETWORK Percentile: Please select only one.** Applicable on Indemnity and SecureFlex plans. PPO non-network plan is at the 85th percentile.
	50th Percentile	

	Fully-insured Ortho	**FULLY-INSURED ORTHODONTIA:** Offered in addition to the non-insured orthodontia that is included with all plans. Insured orthodontia is for groups enrolling at least 10 eligible employees on the PPO, SecureFlex and Indemnity Plans.

MONTHLY ADMINISTRATIVE FEE (Based on the number of insured employees.)
Fee is subject to change, per the fees below, as the number of insured employees changes.

0-24 insureds - $10.00/month • 25-49 insureds - $15.00/month • 50 insureds or more - $25.00/month • PEOs - $50.00/month

REQUESTED EFFECTIVE DATE: _____ **EMPLOYER CONTRIBUTION: Employee** _____**%** **Dependent** _____**%**

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

PARTICIPATION: How many full-time (working 30 or more hours per week) employees do you have, including owners?_____

Are any full-time employees not enrolling for Insurance? ☐ YES ☐ NO If yes, how many and why?_____

COVERAGE REPLACEMENT BENEFITS

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

CONCURRENT 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:_____

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.

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 FIDELITY ASSURANCE COMPANY? ☐ YES ☐ NO
3. Do you carry an Errors and Omission Policy? ☐ YES ☐ NO If yes, who is the carrier? _____

Agency Name:_____ Agent Name: _____

SecureCare Dental 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 Social Security Number _____Broker/Agent federal Tax ID Number_____

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 Fidelity Assurance Company
Oklahoma City, Oklahoma 73125
www.afadvantage.com

SecureCare Dental
3625 North 16th Street, Suite 206
Phoenix, Arizona 85016
Tel: (602) 241-0914 Toll free 1-888-429-0914
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