SECURECARE DENTAL
GROUP INSURANCE

ENROLLMENT / COVERAGE CHANGE FORM

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

SECTION 1: QUALIFYING EVENT (Please Check One)

☐ **Open Enrollment** ☐ **New Hire** ☐ **Plan Change (Complete entire form.)** ☐ **Address/Name Change/Correction**

☐ Add **OR** Delete Dependents (Indicate below date and type of qualifying event. Then complete Sections 3, 4, 5 & 7.)
Date of Event: ___/___/_____ ☐ Marriage ☐ Divorce ☐ New Birth ☐ Adoption ☐ Other:_____

☐ COBRA Continuation ☐ Termination - **Last Day Worked:** ___/___/___ (Complete Sections 3 & 7)
Reason: ☐ Left Employment ☐ Reduced Hours ☐ Other Insurance

SECTION 2: WAIVING COVERAGE

☐ I Do Not Want Coverage – (Complete Sections 3 & 7)

SECTION 3: EMPLOYEE INFORMATION (Please PRINT Clearly)

Social Security Number	Last Name	First Name	M. I.

Street Address (mailing)	City	State	Zip

Gender: ☐ Female ☐ Male	Date of Birth (mm/dd/yyyy) / /	Name of Employer

Position / Division	**Date of Hire (Full-Time) (REQUIRED)** / /	Work Telephone

SECTION 4: PLAN OPTIONS (Please Check One)

☐ **The Copay Plan** ☐ **The PPO Plan** ☐ **The Indemnity Plan** ☐ **The SecureFlex Plan**

SECTION 5: DEPENDENT INFORMATION

Dependent children age 19 to 24 must be full-time students to be eligible. A class schedule or letter from registrar's office with (1) name of institution, (2) student's name, (3) number of credit hours, and (4) semester/quarterly period must be provided at time of enrollment.

Add	Delete	Social Security Number	Last Name (if different), First Name, Middle Initial	Gender	Date of Birth
			(Spouse)		
			(Child)		
			(Child)		
			(Child)		

SECTION 6: OTHER INSURANCE COVERAGE THAT SECURECARE DENTAL IS NOT REPLACING

Will you have concurrent coverage with other group dental insurance that SecureCare Dental is <u>not</u> replacing?
☐ YES– Complete this section. ☐ NO– Skip to Section 7.

Insurance Co. Name	Insurance Co. Phone Number:

Name of Policyholder	Policyholder's S.S. #:

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 7: AUTHORIZATION

I hereby apply for SecureCare Dental 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, 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 dental 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 Date Signed
(Faxed signature bears the full authority of the original signature)

For SecureCare Dental Use Only		
Group Number:	Employee Effective Date:	
Group Effective Date:	Open Enrollment Month:	Waiting Period:

Administered By: **Southwest Preferred Dental Organization**
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Phone: (602) 241-0914 ● Toll-Free: 1-888-429-0914
FAX: (602) 264-8953 ● www.securecaredental.com

Insured and Underwritten By: **American Fidelity Assurance Co.**
(Oklahoma City, OK)