SECURIAN™

Membership Enrollment Form

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PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

Employee's Name:	Last		First			Middle Initial	Social Security Number / /	
Gender:	Male ☐	Female ☐	Marital Status:	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	Date of Birth (Month-Day-Year) / /
Employee's Address:	Address						Day Phone Number	Evening Phone Number
	City			State			Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		Complete If Multiple Plan Options Are Offered
☐ Employee Only*	☐ No Coverage*	I elect to participate in the following Plan:
☐ Employee and Spouse	* If waiving coverage for employee and/or any eligible family members, you must complete Part D.	☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D
☐ Employee and Dependent Child(ren)		
☐ Family		

PART C – DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
Spouse		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

PART D – WAIVE COVERAGE

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: _____ Policy/Identification Number: _____

☐ I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Securian Dental reserves the right to decline any further enrollment changes.

Employee Signature: **Date:**

PART E – EMPLOYEE SIGNATURE

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purposes of misleading, information concerning any fact material thereto may commit a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature: **Date:**

PART F – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date: ____/____/____
Effective Date: ____/____/____

☐ **Rehire**
Date Lay Off Began: ____/____/____
Date Rehired: ____/____/____

☐ **Existing Securian Dental Group Changing Plan**
Hire Date: ____/____/____
Prior Coverage Start Date (if applicable): ____/____/____
Effective Date: ____/____/____

☐ **Return from Leave of Absence**
Date Leave Began: ____/____/____
Date Returned to Work: ____/____/____

☐ **Employee Change Part Time to Full Time**
Date of Status Change: ____/____/____
Effective Date: ____/____/____

☐ **Open Enrollment**
Coverage Effective Date: ____/____/____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Coverage Effective Date
Hire Date: ____/____/____
Effective Date: ____/____/____

☐ **Loss of Coverage** – Employee and/or Dependent
Hire Date: ____/____/____
Date of Loss: ____/____/____
Effective Date: ____/____/____

☐ **Previously Waived Coverage** – Qualifying
Event Reason: _____
Hire Date: ____/____/____
Event Date: ____/____/____
Effective Date: ____/____/____

Group Name: Brunswick School Dept **Group & Subgroup Numbers:** 8093-0103

Group Representative's Signature: **Date:** **Phone Number:** (207)3191900