SECURIAN™
Securian Life Insurance Company

Securian New Business
730 South Broadway
Gilbert, MN 55741
1-866-827-3318
www.securiandental.com

Master Dental Contract Application
Pooled Programs

PART A — Company Information

Legal Company Name		Phone ( )
Address		Tax ID #
City	State	Zip Code

Type of Coverage ❑ Employee Only ❑ Employee and Spouse ❑ Employee and Children ❑ Family

Requested Plan Effective Date (First of the month)

Eligibility waiting period for new employees:
First of the month following _____ Other _____

Does your company currently have a dental plan? ❑ No ❑ Yes (carrier name) _____

(Attach copy of most recent dental billing — if you have current plan)

PART B — Participation

Total number of eligible employees _____

Securian Dental Employer Sponsored Enrollment

- ❑ 2 - 4 Eligible Employees — 100% of employees and 100% of dependents not covered elsewhere under a dental contract must enroll. A minimum of two (2) employees must enroll.
- ❑ 5 - 249 Eligible Employees — The greater of five (5) employees enrolled OR 60% of employees and 60% of dependents not covered elsewhere under a dental contract must enroll. A minimum of ten (10) employees must enroll in Plan B, C or D if the orthodontia benefit is selected.
- ❑ Employee-only Plan — The above participation requirements apply to employees only. Dependent coverage is not offered.

Securian Dental Voluntary Enrollment

- ❑ 2 - 4 Eligible Employees —100% of Employees and 100% of dependents not covered elsewhere under a dental contract must enroll, with a minimum enrollment of two (2) employees.
- ❑ 5 - 249 Eligible Employees — Minimum of five (5) employees enrolled. Orthodontia option is available for Plans B & C at a minimum enrollment of ten (10).
- ❑ Employee-only Plan — The above participation requirements apply to employees only. Dependent coverage is not offered.

Securian Dental MEDICAL LOCK Enrollment

- ❑ 2 - 249 Eligible Employees — 100% of the Employees and 100% of the Dependents enrolled in the inforce group Medical program must enroll in the dental program.
  (INCLUDE A COPY OF THE MOST RECENT MEDICAL BILLING STATEMENT).

RATES SOLD

EE	ES	EC	FM

PART C — Dental Program (Choose One)

☑ **Securian Dental Employer Sponsored Plan**

☐ Plan A without Major Services	Minimum 2 employees
☐ Plan B Comprehensive Coverage	Minimum 2 employees
☐ Orthodontia	With Orthodontia minimum 10 employees
☐ Plan C Comprehensive Coverage	Minimum 2 employees
☐ Orthodontia	With Orthodontia minimum 10 employees
☑ Plan D Comprehensive Coverage	Minimum 2 employees
☐ Orthodontia	With Orthodontia minimum 10 employees

Does the prior dental plan have orthodontic coverage? ☐ No ☐ Yes

Please Note: If you are adding orthodontics and the previous dental plan did not have orthodontic coverage, there will be a 12-month waiting period for orthodontic benefits under the Employer Sponsored Plan B, C and D.

☐ **Securian Dental Voluntary Plan**

☐ Plan A without Major Services	Minimum 2 employees
☐ $500 Annual Maximum Benefit	
☐ $750 Annual Maximum Benefit	
☐ Plan B Comprehensive	Minimum 2 employees with Orthodontia minimum 10 employees
☐ $750 Annual Maximum Benefit	
☐ $1000 Annual Maximum Benefit	
☐ Orthodontia	
☐ Plan C Comprehensive	Minimum 2 employees with Orthodontia minimum 10 employees
☐ $1000 Annual Maximum Benefit	
☐ $1250 Annual Maximum Benefit	
☐ Orthodontia	

Waiver of waiting periods benefit election? ☐ No ☐ Yes

(Most recent and prior/inforce dental carrier billing statement required to be considered for waiting period waiver.)

RATES SOLD			
EE	**ES**	**EC**	**FM**

AGENT OF RECORD (if any) completion of all fields is required

Name	Agency	
Address	Phone ( )	
City	State	Zip Code

X _____

Agent's Signature

_____

Securian Life Agent Number

PREMIUM REMITTANCE

The first month's premium must accompany the application. Thereafter, DeCare Dental Health International, LLC, administrator for Securian Dental Plans, must receive monthly billings and the appropriate remittance on the first of each month.

1. Complete the Master Dental Contract Application for Pooled Programs. Retain a copy for your files.
2. Have each employee complete and sign a Membership Enrollment Form.
3. Send the original application, completed Membership Enrollment Forms and the first month of premium to the address on top right of page one - Attn: Securian Connect. For questions call 1-866-201-1818.

Please Select Payment Option:

❑ **ACH Automatic Check Handling**
(include ACH Authorization Form and voided check)
(ACH Premiums are reduced by .25% for this option.)

❑ **Monthly Billing**

Group Administrator:

By signing below, I verify that the information on this application is correct and that the eligible employees are in fact employed by my company and agree to provide substantiating evidence when requested. If issued, the contract may become null and void at the option of Securian Life if for a period of three consecutive months, or upon renewal, the number of enrolled employees becomes less than two, or contracted participation guidelines are not met. Securian Life has permission to contact trade and bank references, access commercial and or consumer credit reporting agencies.

Securian Life will send a contract upon acceptance of the application. The contract will indicate the effective date of coverage. The contract is effective only after Securian Life has accepted this application and sent a contract to the group. The group administrator's signature does not cause the application to become effective as a contract. Any misrepresentations of submitted data will cause the contract, if issued, to be null and void at the option of Securian Life.

SIGNATURE BOX

X _____ _____ _____

Signature (Group Administrator) | Title | Date

Please send all future correspondence to:

Group Administrator's Name (please print)	Phone Number ( )
E-mail Address	Fax Number ( )

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Membership Enrollment Form

SECURIAN™

www.securiandental.com

INSTRUCTIONS PROVIDED ON BACK

PART A – EMPLOYEE INFORMATION

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		Home Phone Number	Work Phone Number
City	State	Zip Code	

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):

- ☐ Employee Only*
- ☐ Employee and Spouse
- ☐ Employee and Dependent Child(ren)
- ☐ Family
- ☐ No Coverage*

* **If waiving coverage for employee and/or any eligible family members, you must complete Part D.**

Complete If Multiple Plan Options Are Offered

I elect to participate in the following Plan:

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D

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	If Over Age 19, Full-Time Student?
Spouse		M	F	/ /	
Dependent Child		M	F	/ /	☐ Yes ☐ No
Dependent Child		M	F	/ /	☐ Yes ☐ No
Dependent Child		M	F	/ /	☐ Yes ☐ No

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. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. 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 commits 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: **Group & Subgroup Numbers**:

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