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 _____

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:

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

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

Address	Apt/Suite #	City	State	Zip Code

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

Email Address:	Class:

*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 4.

DEPENDENT INFORMATION

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

Short Term Disability	☐ Employee ☐ Waive	Plan Code:		Disability Coverage Amount:	$

PREMIER PARTNER PRODUCT SELECTION

Select your plan(s).

Healthiest You Telemedicine	**InfoArmor** Identity Protection	**LegalEase** Legal Plans	**Whisker Docs** Pet Help Line
☐ EMP ☐ FAM ☐ Waive	☐ EMP ☐ FAM ☐ Waive	☐ EMP ☐ FAM ☐ Waive	☐ Enroll ☐ 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

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

SECTION B: SHORT TERM DISABILITY - GENERAL QUESTIONS (Simplified Issue/Fully Underwritten or Late Entrant Only)

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

If you answer any medical questions for Short-Term Disability coverage, you are required sign and date the Medical Release of Information on page 3.

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Employee Name:		Group Name or ID:	

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)

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

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)

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Employee Name:		Group Name or ID:	

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.

Arizona 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 is subject to criminal and civil penalties.

Colorado Fraud Warning: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Nevada Fraud Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

Texas Fraud Warning: 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.

Utah Fraud Warning: Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits, or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state 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

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

Administered by:
Southwest Preferred Dental Organization
4745 N 7th Street Suite 120
Phoenix, AZ 85014

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