P.O. Box 2145
Grand Rapids, MI 49501-2145
(616) 454-4000 or (800) 876-7475
www.secureoneinc.com

Group Enrollment Application
Dental and Vision

APPLICATION MUST BE COMPLETED IN FULL OR YOUR CLAIMS MAY BE DELAYED OR DENIED.

EMPLOYER INFORMATION

Employer Name: ____

Employer Address: ____
Number/Street

City__________________________ State__________ Zip__________

EMPLOYEE INFORMATION

Employee Name: ____
Last First Initial

Address: ____
Number/Street

City__________________________ State__________ Zip__________

SSN: ________-________-________ Phone Number ( ) ____________

Sex: ☐ Male ☐ Female Birth Date: ____________ Hire Date: ____________

Occupation ____________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Legally Separated

WAIVING COVERAGE

Complete this section if you are **NOT APPLYING** for full coverage for yourself and your dependents.

I certify I was given the opportunity to apply for group benefits offered by my employer, and I do not accept the offer.

Waive Dental Coverage ☐ Myself and Dependents ☐ Spouse Only ☐ Child(ren) Only

Waive Vision Coverage ☐ Myself and Dependents ☐ Spouse Only ☐ Child(ren) Only

If I elect to waive coverage for benefits shown above, I ☐ certify ☐ do not certify that I am doing so because I have other health coverage.

COVERAGE ELECTION

☐ Employee Only ☐ Employee Spouse
☐ Family (Please complete dependent information below.) ☐ Employee Child

DEPENDENT ENROLLMENT INFORMATION (Please check the appropriate box(es) and fill in the information below.)

Relationship	First Name	Last Name	Sex	DOB	SSN
☐ Spouse					
☐ Natural/Adopted Child ☐ Step-Child*					
☐ Natural/Adopted Child ☐ Step-Child*					
☐ Natural/Adopted Child ☐ Step-Child*					
☐ Natural/Adopted Child ☐ Step-Child*					
☐ Natural/Adopted Child ☐ Step-Child*					

***By including my step-child(ren) and signing this application, I verify that the above child(ren) is (are) primarily dependent upon me for care and financial support and living with me in a parent-child relationship. (Please include a copy of the step-child's birth certificate for our records.)**

PLEASE NOTE: For children attending school who are age 19 through the limiting age indicated in your Plan Document, please provide a copy of their full-time student schedule from the accredited college, university or educational institution. Without this, claims for this dependent may be delayed or denied.

OTHER INSURANCE INFORMATION

Do any of your above dependent(s) have other insurance? ☐ Yes ☐ No

First and Last Name	Type(s) of other insurance	Insurance Carrier/ Address/Phone #	Policyholder's Name/ Date of Birth/Employer
	☐ Medical/Rx ☐ Dental ☐ Vision		
	☐ Medical/Rx ☐ Dental ☐ Vision		

CONTINUOUS COVERAGE

You and your dependents have the right to prove you had previous continuous coverage. You should have received a **certificate of creditable coverage** from your previous carrier. If you did not get a certificate, you should request one from the previous plan or insurer.

*Have you had previous dental coverage? ☐ Yes ☐ No
*Have your dependents had previous dental coverage? ☐ Yes ☐ No

***IF YOU HAVE CHECKED "YES" TO THE ABOVE QUESTION(S), PLEASE PROVIDE A COPY OF YOUR CERTIFICATE OF CREDITABLE COVERAGE. WITHOUT THIS CERTIFICATE, YOUR CLAIMS MAY BE DELAYED OR DENIED.**

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other group health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 30 days after a qualifying event. A qualifying event would include loss of coverage through no fault of your own, marriage, birth, adoption, or placement of adoption. If coverage is waived without having other group health insurance, and if you or your dependents choose to apply for coverage under this plan at a later date, you will be treated as a late entrant and subject to the late entrant pre-existing limitations and contract provisions.

ANNUAL OPEN ENROLLMENT PERIOD

You or your dependents may also enroll for group insurance benefits under this Plan by submitting a completed enrollment form during an annual open enrollment period. The annual open enrollment period will begin as designated by the Employer once every Calendar Year and will be for a period of 31 days. The Employer is responsible for advising all of its Employees of annual open enrollment periods.

AUTHORIZATION TO RELEASE INFORMATION

I understand that by law, health care providers, my employer, and SecureOne and other entities providing services in connection with the Plan can use/disclose my individually identifiable health information for health care treatment, health care payment and health plan operations purposes subject to a minimum necessary standard. Notwithstanding, I specifically authorize any provider, facility or supplier to give all data about me to the insurer. This is also valid for my dependents. I agree the insurer will use this data, including, but not limited to, attending physician(s) statements, to determine eligibility, coverage of benefits, and underwriting criteria. I may request a copy of this data at any time. The insurer will not release data to any person or entity. A photographic copy of this authorization shall be as valid as the original for 30 months from the date below. I know that I, or my authorized representative, may request and are entitled to receive a copy of this authorization. I authorize the use/disclosure of the individually identifiable health information of myself and my minor dependents by or to my spouse, my employer, any health care provider, SecureOne or any entity providing services in connection with the Plan in order to process my enrollment in the Plan or process any claim for any Plan benefits.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing this consent. I understand that SecureOne reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by contacting them. I understand that I have the right to restrict how SecureOne uses or discloses my protected health information to carry out payment or health operations; that SecureOne is not required to agree to the restrictions and; that SecureOne is bound by the restrictions to which it agrees. I have the right to revoke this consent by notifying SecureOne in writing, except to the extent that SecureOne has taken action in reliance on my consent.

DISCLOSURES

I understand no insurance exists unless and until my employer receives notification in writing from SecureOne Benefit Administrators, Inc.'s office indicating coverage for my dependents and me is active and the effective date of the coverage. If, at any time prior to such notification, my dependents or I consults a doctor, is hospitalized, or has any change in health, I agree to inform SecureOne Benefit Administrators, Inc.'s office immediately.

I understand the agent does not have the authority to change or waive any of the provisions of this application, nor any of the provisions, terms or conditions or any other forms or materials supplied by the Plan or SecureOne Benefit Administrators, Inc., nor bind the Plan to any promises of coverage.

I am aware that I may be required to contribute toward the cost of my insurance premium as indicated by my employer. I ask my employer to deduct my portion of the premium for this insurance from my pay.

I understand I may be contacted by phone by SecureOne Benefit Administrators, Inc. on behalf of the Plan during the regular business hours of SecureOne Benefit Administrators, Inc. to confirm/obtain information.

I/We have read the group enrollment application and have completed the sections that apply to my/our requirements.

Employee Signature____ Date________________

Spouse Signature____ Date________________

DO NOT WRITE IN THIS AREA

Group #__________________ Effective Date________________

Coverage: ☐ EE ☐ FAM ☐ ES ☐ EC

Type of Coverage: ☐ Dental ☐ Vision

Term Date: _______________ Reins. Date: _______________ COBRA Start: _______________

Rehire Date: _______________ Term Date (2) : _______________ COBRA End: _______________

Date Completed:________________