



Mail completed application and forms to:
Matrix Insurance Marketing, Inc.
1225 So. Weller St. Suite 320
Seattle, WA 98144-1906
(206) 521-9451 (800) 929-6123
Fax (206) 521-9554

New Business Checklist Securian Dental Plans

- Completed Master Employer Application
- Completed Membership Enrollment Forms
- First Month's Premium Check made payable to Securian Dental Plans
- Copy of Dental quote sold or rate sheet indicating plan, participation and rates sold
- Current dental carrier billing statement and copy of current plan/benefit page to verify comparable coverage (if replacing dental plan)

Part A – Company Information

- Type of Coverage: If Employee Only is selected, dependent coverage will not be available to current and future employees

Part B - Participation

- Indicate total number of eligible employees (all employees working 20 or more hours per week)
- Indicate Employer Paid or Voluntary
- See Participation Guidelines for enrollment requirements on Employer Paid and Voluntary plans

Part C – Dental Program

- Plan Design selected

Signatures as required

Coverage eligibility for groups which are 50% or more family related by blood, marriage or adoption is as follows:

Employer Paid & Voluntary Plans:

Groups with 2 - 4 employees are not eligible for coverage.

Groups with 5 - 249 employees, Wage & Tax Form is required.

- Complete all sections

NOTE: Detailed instructions are included as part of Membership Enrollment Form

Key Issues

Part B – Must be completed. If waiving coverage for employees and / or any eligible family member, Part D must also be completed

** Please submit this checklist with all of your new business*



Securian Life Insurance Company

Send Completed Forms to:
 Matrix Insurance Marketing, Inc.
 1225 So. Weller St., Suite 320
 Seattle, WA 98144
 Phone: 206.521.9451
 Fax: 206.521.9554
 Email: info@matrixinsurance.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 <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Children <input type="checkbox"/> Family			
Requested Plan Effective Date (First of the month) _____ <input type="checkbox"/> 24 month rate guarantee			
Eligibility waiting period for new employees: First of the month following _____ Other _____			
Does your company currently have a dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes (carrier name) _____			
<i>(Attach copy of most recent dental billing — if you have current plan)</i>			
PART B — Participation			
Total number of eligible employees _____			
Securian Dental Employer Sponsored Enrollment			
<input type="checkbox"/> 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.			
<input type="checkbox"/> 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.			
<input type="checkbox"/> Employee-only Plan — The above participation requirements apply to employees only. Dependent coverage is not offered.			
Securian Dental Voluntary Enrollment			
<input type="checkbox"/> 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.			
<input type="checkbox"/> 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).			
<input type="checkbox"/> Employee-only Plan — The above participation requirements apply to employees only. Dependent coverage is not offered.			
Securian Dental MEDICAL LOCK Enrollment			
<input type="checkbox"/> 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
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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.



SECURIAN™

Automated Clearinghouse

Authorization Agreement

Company Name _____

authorizes the charge to our bank account through the Automated Clearinghouse
(ACH) for the **Total Amount Due** according to our Invoice / Statement.

Group Number _____

ACH Effective Date _____

Bank Name _____

Bank Address _____

Bank Account Number _____

Type of Account: Checking Savings

Bank Account Name _____

Bank Routing Number _____

(between these symbols  on the bottom left of your check)

PLEASE INCLUDE A VOIDED CHECK

Authorized individual of the Account _____

Print

Signature

Today's Date

Title

Telephone Number

Questions? Please call our Billing and A/R Department at: 1-866-201-1818 (Option 4)

Please complete this form and fax to us at 206.521.9554

or,

Please complete this form and mail to:

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1225 So. Weller St. Suite 320
Seattle, WA 98144-1906
(206) 521-9451 (800) 929-6123
Fax (206) 521-9554



Membership Enrollment Form

www.securiandental.com

INSTRUCTIONS PROVIDED ON BACK

PART A – EMPLOYEE INFORMATION

Employee's Name: Last First Middle Initial		Social Security Number / /	
Gender: Male Female <input type="checkbox"/> <input type="checkbox"/>	Marital Status: Single Married Widowed Divorced Legally Separated <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Date of Birth (Month-Day-Year) / /
Employee's Address:	Address		Home Phone Number
	City	State	Zip Code
		Work Phone Number	

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		Complete If Multiple Plan Options Are Offered
<input type="checkbox"/> Employee Only* <input type="checkbox"/> No Coverage* <input type="checkbox"/> Employee and Spouse * If waiving coverage for employee and/or any eligible family members, you must complete Part D. <input type="checkbox"/> Employee and Dependent Child(ren) <input type="checkbox"/> 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	If Over Age 19, Full-Time Student?
Spouse		M	F	/ /	
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> 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. 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

<input type="checkbox"/> New Group Hire Date: ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Rehire Date Lay Off Began: ____/____/____ Date Rehired: ____/____/____
<input type="checkbox"/> Existing Securian Dental Group Changing Plan Hire Date: ____/____/____ Prior Coverage Start Date (if applicable): ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Return from Leave of Absence Date Leave Began: ____/____/____ Date Returned to Work: ____/____/____
<input type="checkbox"/> Open Enrollment Coverage Effective Date: ____/____/____	<input type="checkbox"/> Employee Change Part Time to Full Time Date of Status Change: ____/____/____ Effective Date: ____/____/____
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Coverage Effective Date Hire Date: ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Loss of Coverage – Employee and/or Dependent Hire Date: ____/____/____ Date of Loss: ____/____/____ Effective Date: ____/____/____
<input type="checkbox"/> Previously Waived Coverage – Qualifying Event Reason: _____ Hire Date: ____/____/____ Event Date: ____/____/____ Effective Date: ____/____/____	

Group Name: _____ Group & Subgroup Numbers: _____

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



Membership Enrollment Form

www.securiandental.com

INSTRUCTIONS PROVIDED ON BACK

PART A – EMPLOYEE INFORMATION

Employee's Name: Last First Middle Initial		Social Security Number / /	
Gender: Male Female <input type="checkbox"/> <input type="checkbox"/>	Marital Status: Single Married Widowed Divorced Legally Separated <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		Date of Birth (Month-Day-Year) / /
Employee's Address:	Address		Home Phone Number
	City	State	Zip Code
		Work Phone Number	

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		Complete If Multiple Plan Options Are Offered
<input type="checkbox"/> Employee Only* <input type="checkbox"/> No Coverage* <input type="checkbox"/> Employee and Spouse * If waiving coverage for employee and/or any eligible family members, you must complete Part D. <input type="checkbox"/> Employee and Dependent Child(ren) <input type="checkbox"/> 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	If Over Age 19, Full-Time Student?
Spouse		M	F	/ /	
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent Child		M	F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> 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. 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

<input type="checkbox"/> New Group Hire Date: ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Rehire Date Lay Off Began: ____/____/____ Date Rehired: ____/____/____
<input type="checkbox"/> Existing Securian Dental Group Changing Plan Hire Date: ____/____/____ Prior Coverage Start Date (if applicable): ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Return from Leave of Absence Date Leave Began: ____/____/____ Date Returned to Work: ____/____/____
<input type="checkbox"/> Open Enrollment Coverage Effective Date: ____/____/____	<input type="checkbox"/> Employee Change Part Time to Full Time Date of Status Change: ____/____/____ Effective Date: ____/____/____
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Coverage Effective Date Hire Date: ____/____/____ Effective Date: ____/____/____	<input type="checkbox"/> Loss of Coverage – Employee and/or Dependent Hire Date: ____/____/____ Date of Loss: ____/____/____ Effective Date: ____/____/____
<input type="checkbox"/> Previously Waived Coverage – Qualifying Event Reason: _____ Hire Date: ____/____/____ Event Date: ____/____/____ Effective Date: ____/____/____	

Group Name: _____ Group & Subgroup Numbers: _____

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

Instructions for Completion of Securian Dental Enrollment Form

Important Notes:

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format.
- Before submitting, review to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt by Securian Dental Plans.

Employee – Complete PARTS: A, B, C, D, E

PART A: EMPLOYEE INFORMATION – Complete All Sections

PART B: ENROLLMENT INFORMATION

Select Coverage Type

- Select one category that describes your eligible dependents that you want covered under your dental plan.
- If you select *No Coverage*, you and your eligible dependents will not be enrolled and coverage is waived. If this option is selected, you must complete Part D.

Plan Options – Complete if Group Offers Multiple Benefit Plan Options

- Select only one option: Plan A, Plan B, Plan C or Plan D.

PART C: DEPENDENT INFORMATION – Complete Only if Enrolling Eligible Dependents

- Complete each section for each eligible dependents being enrolled.
- If enrolling more than four dependents, attach a list of additional dependent information in the same format.

PART D: WAIVE COVERAGE

- This section must be completed if in Part B you selected *Employee Only* and have eligible dependents or if you selected *No Coverage*.
- Complete other insurance coverage information.
- Check box to indicate you waive coverage.
- Sign and date the form as verification of your selection.

PART E: EMPLOYEE SIGNATURE

- Please read, sign and date the form as verification of your selection.
- If you selected *No Coverage* in Part B and completed Part D, a signature is not required in Part E.
- Return completed form to your benefit administrator.

Employer Complete PART F: GROUP ENROLLMENT INFORMATION

- Review sections completed by employee to assure information provided is complete, accurate and legible.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., first of the month, end of month, or actual dates).
- Check one section that describes reason Membership Enrollment Form is being submitted.
- Complete all dates in applicable section:
 - Hire Date – Date employee was employed by group.
 - Effective Date – Date the individual's dental benefits begin.
 - Prior Coverage Start Date – Is used in administration of benefit waiting periods. Provide effective date of group's prior qualified dental plan. Date does not apply if group did not previously have a qualified dental plan.
 - Event Date – Date of qualifying event that allows additions or changes to employee's enrollment selection (i.e., date of marriage, date of divorce, date of adoption, etc.)
- **New Group** – New customer to Securian Dental and submitting initial employee enrollment. Complete all dates.
- **Existing Securian Dental Group Changing Plan** – Existing Securian Dental customer changing benefits from Plan A to Plan B or Plan C and submitting employee enrollment. Complete all dates.
- **New Hire** – Enroll newly hired employee. If probationary period applies, effective date is after the probationary period.
- **Rehire** – Former employee was laid off and is being rehired.
- **Return From Leave of Absence** – Employee returning from leave of absence.
- **Loss of Coverage** – Employee/dependent involuntarily lost other dental coverage and is now eligible to enroll.
- **Previously Waived Coverage** – Enrolled employee had eligible family status change such as: marriage, divorce, birth, adoption, which allows dependents to be added.
- **Employee Change Part-Time to Full-Time** – Employee's employment status changed and employee is now eligible for dental benefits.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Form To:

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