The Securance Group

Benefits Enrollment Form

Please complete the following information:					
Social Security No.	Last Name		First	Middle	Date of Birth
Home Address			Home Phone		Gender
City	State	ZIP Code	Business Phone		Facility Number

List All Your Eligible Dependents That Are To Be Covered			
First MI Last	Facility Number	Sex	Birth Date
Spouse:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /
Child:		M☐ F☐	/ /

Effective Date:	Plan Code:	Group Number **See Below**	Your E-mail Address	Agent Number

PLEASE CHECK YOUR CHOICE	☐ **Dental Plan CD3149**	☐ **Vision Plan VS4211**
Monthly Rates		
Employee Only	☐ **$ 24.78**	☐ **$ 8.04**
Employee + One	☐ **$ 47.44**	☐ **$ 16.04**
Employee + Family	☐ **$ 78.00**	☐ **$ 21.44**

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X _____ Date: _____