SafeGuard Dental Enrollment Form
California

Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator.

Benefits Coordinator Use Only

Group/Employer Name	Group No.	Effective Date	Date of Hire

Subscriber's Information

Plan Selected: _____

Last Name	First Name	MI	Subscriber SS#
			- -

Home Address	Apt. #

City	State	Zip Code

Male/Female	Date of Birth	Home Telephone	Work Telephone	Ext.
		( )	( )	

Dependent Information

Spouse/ Dependent	Last Name	First Name	MI	Male/ Female	Date of Birth		
					Mo.	Day	Year

Primary language: _____ **Please note any communication impairment:** _____

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Authorization to release dental records - I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental records which pertain to me or any member of my family, maintained by my chosen Selected General Dentist and/or Specialist, to SafeGuard and/or any designated agent or representative for the purposes of dental treatment, care and for SafeGuard's quality assessment and utilization reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

☐ I hereby apply to SafeHealth Life Insurance Company for Group Dental Insurance as presented to me and authorize my employer to make any necessary deduction from my salary to pay the premium when my insurance becomes effective.

Waiver of Coverage

I have been given the opportunity to apply for group dental insurance, but:

☐ Do not choose to elect this coverage.

Visit our website at www.safeguard.net for up-to-date provider listings.

Your Name (Please Print)	Your Signature	Date