SafeGuard

☒ Initial Application

☐ Renewal Acknowledgement

SafeHealth Life Insurance Company
95 Enterprise, Suite 100
Aliso Viejo, CA 92656-2605

APPLICATION & ACKNOWLEDGEMENT GROUP DENTAL INSURANCE BENEFITS

NEW PROVISION(S): If any one of the following boxes are checked, attached hereto are new benefits and/or exclusions and limitations which are hereby incorporated by reference herein into the agreement and policy between SafeHealth Life Insurance Company ("SafeHealth") and Organization, referred to below. **Important Note: This Application and Acknowledgement should be signed and returned to us to ensure the continuation of your dental benefits plan. € Benefits € Exclusions € Limitations**

Organization Policyholder Name *(full legal name)*		**Group No.**
Organization is a € Corporation € Partnership € Sole Proprietor € Government Agency € Union Trust		
Street / P. O. Box Number		
City State **CA** Zip		
Telephone Fax ( )		
Contact	Contact Title	Contact Telephone ( )

Plan Code Name:	Classes of employees to be covered	
Approved Rates (per SafeHealth): Enrollee Only $ Enrollee + One $ Enrollee + Family $ Composite $ *(if applicable)*	☐ All Employees ☐ Retirees ☐ Union ☐ Salaried ☐ Non-Union	Employer pays _____% of employee premium _____% of dependent premium Number of Eligible Employees _____

SAFEHEALTH, subject to all the conditions and provisions of the POLICY, and in reliance upon the statements of each Enrollee of the Organization in his or her Enrollment Card, shall provide the services and benefits and the other rights and privileges which are set forth in the POLICY, which shall take effect on **1,** the "Effective Date", and shall continue for a period of year.

All employees are to be eligible on the effective date except part-time and disabled employees. Employees who commence work after the effective date, shall be eligible on the first of the month following completion of _____ days of continuous active employment.

If employer is multi-site, please note name and address of any subsidiary or affiliated companies to be included under the POLICY on the reverse of this Agreement. Formal documents govern all rights and benefits; for full and complete policy information, please refer to your Master Policy.

If any of Organization's locations are to be excluded from the POLICY, please note name and address in the appropriate area below.

If group is multi-site, locations to be covered under the POLICY (must have been included in underwriting process)

If group is multi-site, locations to be excluded under the POLICY (must NOT have been included in underwriting process)

It is understood that no person, except an authorized Officer of SafeHealth Life Insurance Company, has the authority to modify, enlarge or vary any policy or to waive any requirement in any policy.

$ _____ is submitted with this Application Agreement to be applied toward the first month's premium.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In witness whereof, the parties have affixed their signatures to this Application Agreement as of the dates set forth below.

ORGANIZATION

Dated at _____ this _____ day of _____ , _____

Organization _____ Tax I.D. # _____

Authorized Organization Representative _____
(please print)

Signature _____ Title _____

Broker Information

Broker Name _____ Broker License # _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

SAFEHEALTH LIFE INSURANCE COMPANY

Dated at Aliso Viejo, CA this _____ day of _____ , _____

SafeHealth Life Insurance Company Representative Robin Muck
(please print)

Signature _____ Title Vice President