



Group Enrollment Form

To ensure that you're correctly enrolled in the plan(s) you have selected, make sure to fill the form out completely. Failure to complete this form with all requested information may result in delays in receiving care. **With these plans, care is provided by network dentists and eye care professionals ... make sure you include the facility numbers for the providers you've chosen.**

***Check the plan(s) you are enrolling in:**

Dental Plans:

1000 2000 3000 SM600
 1000S 2000S 3000S

Vision Plans:

SM10 SM20/20 SM30

Stand Alone Orthodontia:

*Plan names are in your benefit information packets.

Benefits Coordinator Use Only

Group/Employer Name	Group No.	Effective Date	Date of Hire
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Subscriber's Information

Last Name		First Name		MI	Subscriber SS#	
Home Address						Apt. #
City			State		Zip Code	
Male/Female	Date of Birth	Home Telephone ()		Work Telephone ()		Ext.
Must be completed to enroll in plan(s):		Dentist Facility # - 1st Choice	Dentist Facility # - 2nd Choice		Vision Facility #	

Facility numbers are found next to each providers name in the Directory and on the website at www.safeguard.net. List below all your dependents that are eligible for coverage.

	Last Name	First Name	MI	Sex	Birthdate	Dentist Facility #1	Dentist Facility #2	Vision Facility #
Spouse								
Child #1								
Child #2								
Child #3								
Child #4								
Child #5								

Must be completed to enroll in plan(s)

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

Agreement - I understand that any dispute or controversy which may arise between SafeGuard Health Plans, Inc., a California Corporation ("SafeGuard") and my Organization or between myself and Safeguard, may be submitted to binding arbitration in lieu of a jury or court trial. This may not apply in all states.

Authorization to release dental/vision records - Authorization to release dental/vision records - I hereby authorize the release and disclosure to review, or to obtain a copy of, any and all dental/vision records which pertain to me or any member of my family, maintained by my chosen selected provider and/or specialist, to Safeguard and/or any designated agent or representative for the purposes of dental/vision 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.

Waiver of Coverage

I have been given the opportunity to apply for group dental insurance, but do not choose to elect this coverage.



Your Name (Please Print)	Your Signature	Date
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SmileSaversm Dental & Vision products are provided by SafeGuard Health Plans, Inc.