

SafeGuard PPO/Indemnity Enrollment Form

How to Enroll:

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

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.	

Check one:

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Children	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Waive Coverage
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Dependent Information

Please Print	Last Name	First Name	MI	Male/ Female	Date of Birth		
					Mo.	Day	Year
Spouse							
Child							
-							
-							
-							

Primary language: _____ Please note any communication impairment: _____

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

I hereby apply to SafeHealth Life Insurance 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.

Your Name (Please Print)	Your Signature	Date
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Waiver of Coverage

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

- Do not choose to elect this coverage.
- Am covered under spouse's dental plan with _____
Name of Insurance Company

