

SafeGuard Dental Enrollment Form Florida

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
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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:** _____

SafeHealth does not require an HIV test 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.



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.

Your Name (Please Print)	Your Signature	Date
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