SafeGuard Vision 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

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.

Dependent Information

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

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

Authorization to release vision records - I hereby authorize the release and disclosure to review, or to obtain a copy or, any and all vision records which pertain to me or any member of my family, maintained by my releasing Optometrist, to SafeGuard and/or any designated agent of representative for the purposes of vision treatment and/or care, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

SafeHealth does not require an HIV test as a condition of obtaining health insurance coverage.

☐ I hereby apply to SafeHealth Life Insurance Company for vision coverage as presented to me.

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.

Waiver of Coverage

I have been given the opportunity to apply for group vision 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