MetLife

SafeGuard Dental HMO Enrollment Form (California)

Benefits provided by SafeGuard Health Plans, Inc., a MetLife company

Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator. Choose a general dental office (facility number) of your choice for each eligible family member from the SafeGuard Directory of Participating Dentists. Failure to do so may result in delays in receiving dental care. If your first provider facility selection is not available, SafeGuard will process your second selection.

Benefits Coordinator Use Only

Group/Employer Name	Group No.	Effective Date	Date of Hire
Employee's Occupation	Division	Class	Dept. Code

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:	**Facility Number - 1st Choice**	**Facility Number – 2nd Choice**

Facility numbers are found next to each General Dentist's name in the SafeGuard Directory of Participating Dentists.

Dependent Information

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	**Facility Number 1st Choice**	**Facility Number 2nd Choice**

Must be completed to enroll in plan:

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

Agreement - I understand that any dispute or controversy which may arise between SafeGuard and my Organization or between myself and SafeGuard Health Plans, Inc., 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 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.

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

"DHMO" is used to refer to "Specialized Health Care Service Plans" in California.