



Employee 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. We cannot guarantee access to care if information is missing. **With these plans, care is provided by a network dentist or eye care professional ... make sure you include the code number 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

*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 Code #	Ortho Code #		Vision Code #	

List below all your dependents that are eligible for coverage. Select one vision provider and up to three general dentists and orthodontists per family (one general dentist per member).

	Last Name	First Name	M.	Sex	Birthdate	Dentist Code #	Ortho Code #	Vision Code #
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 SmileSaver, a division of SafeGuard Health Plans, Inc., a California Corporation ("SmileSaver") and my Organization or between myself and SmileSaver, 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 SmileSaver and/or any designated agent or representative for the purposes of dental/vision treatment, care and for SmileSaver'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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