

## Safeguard Application Instructions

1. Print in pen and make sure the application is clear and readable. If you are enrolling family members, make sure their information is entered as well.
2. Select two (2) dental care providers from the Safeguard directory (they ask for a first and second choice). This directory can be found online at:

<http://directory.safeguard.net/sg4c.asp?pb=sg3&mnu=1> or [you can just click here](#).

Each enrolled family member may select a different dentist.

3. Make sure you indicate the Facility number (the number next to the dentist's name in the directory).
4. Check the payment method you have selected. There are a number of options:
  - a. You can pay annually by check or credit card. If you use a check, make sure to include the one-time only \$20 application fee.
  - b. You can also pay monthly by automatic bank draft or credit card draft. If you use bank draft be sure to include a voided check or deposit slip. Remember to sign the banking information portion of the form.
5. Calculate the payment based on the payment method you choose. Enter that amount in the "Total Amount Due" space.
6. Read the "Use and Disclosure" statement and sign and date where indicated at the bottom of the form.

Mail the application to:

Safeguard Health Plans Inc.  
Attn: Individual Billing  
P.O. Box 8095  
Laguna Hills, CA 92654-8095



# Individual & Family Enrollment Application - Texas

Agent #: **22757**

Last Name		First Name			M.I.	Social Security Number	
Home Address				City (Complete Name)		State	Zip Code
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	Month	Day	Year	Day Time Phone (     )	
Primary Language		Please note any communication impairment					

<b>Must be completed to enroll in plan:</b>			<b>Facility Number 1st Choice</b>	<b>Facility Number 2nd Choice</b>
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**Dependent Information (attach a separate sheet for additional dependents)**

Circle One	Circle One	Last Name	First Name	MI	Date of Birth Mo/Day/Yr	Disability Y/N	Facility Number 1st Choice	Facility Number 2nd Choice
Spouse	Male					Yes		
Child	Female					No		
Spouse	Male					Yes		
Child	Female					No		
Spouse	Male					Yes		
Child	Female					No		

Select Your Payment Method - check one:  Annual Check  Annual Credit Card  Monthly Credit Card Draft  Monthly Bank Draft

Classic Choice			Premier Choice		
I am enrolling (check one)	Annual	Monthly	I am enrolling (check one)	Annual	Monthly
Myself alone	<input type="checkbox"/> \$ 94.44	<input type="checkbox"/> \$ 8.00	Myself alone	<input type="checkbox"/> \$145.20	<input type="checkbox"/> \$ 12.29
Myself & one dependent	<input type="checkbox"/> \$186.00	<input type="checkbox"/> \$ 15.75	Myself & one dependent	<input type="checkbox"/> \$273.48	<input type="checkbox"/> \$ 23.16
Myself & my family	<input type="checkbox"/> \$283.44	<input type="checkbox"/> \$ 24.00	Myself & my family	<input type="checkbox"/> \$415.80	<input type="checkbox"/> \$ 35.21
Add the application fee (*non-refundable/1-time fee)	\$ 20.00*	\$ 20.00*	Add the application fee (*non-refundable/1-time fee)	\$ 20.00*	\$ 20.00*
<b>TOTAL AMOUNT DUE:</b>	<b>\$</b>	<b>\$</b>	<b>TOTAL AMOUNT DUE:</b>	<b>\$</b>	<b>\$</b>

<b>Credit Card Information</b>  Please charge my (check one) <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express  Credit Card No: _____ Expiration date: _____	<b>Banking Information</b> - Please debit my (check one) <input type="checkbox"/> Checking account (include a voided check) <input type="checkbox"/> Savings account (include a voided deposit slip)  I hereby authorize SafeGuard to debit the designated prepayment fee each month from the bank account indicated above. I understand that the amount of my monthly prepayment fee will be deducted from my account and that there will be a \$15 service charge for any returned drafts.
Authorization/ Signature: _____ Date: _____	Authorization/ Signature: _____ Date: _____

**Use and Disclosure of Personal Health Information:**

**Agreement** - I understand that any dispute or controversy which may arise 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/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 SafeGuard and/or any designated agent or representative for the purposes of dental/vision 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.

**Mail to: SafeGuard Health Plans, Inc.**  
**Individual Billing**  
**PO Box 8095**  
**Laguna Hills, CA 92655-8095**

**I understand that the initial term of the Contract is for one year.**

Signature: _____	Date: _____
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## EFFECTIVE DATES OF COVERAGE

The date your SafeGuard dental & vision coverage becomes effective is based on when we receive your application and payment. If you have questions after reviewing the following, please contact us at 800.936.0324.

**ANNUALLY BY CHECK OR CREDIT CARD:** If your application and payment is received by the 20th of the month, you will be able to use your benefits on the first day of the following month. (e.g. received by March 20, your benefits will be effective April 1. After the 20th of March your benefits will be effective May 1.)

**MONTHLY BANK DRAFT:** If your application and payment is received by the 10th of the month, you will be able to use your benefits on the first day of the following month. (e.g. received by March 10, your benefits will be effective April 1. After the 10th of March, your benefits will be effective May 1.)

**MONTHLY CREDIT CARD DRAFT:** If your application and payment is received by the 20th of the month, you will be able to use your benefits on the first day of the following month. (e.g. received by March 20, your benefits will be effective April 1. After the 20th of March, your benefits will be effective May 1.)