

SmileSaver Individual & Family Enrollment Application

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 ... make sure you include the facility number for the providers you've chosen.**

Broker #: **23928** General Agent #: **20046** Master General #: **20046**

Last Name		First Name		MI	Subscriber SS#	
Home Address						Apt. #
City				State		Zip Code
Male/Female	Date of Birth	Home Telephone ()		Work Telephone ()		Ext.

Plan Selected: Dental: <input type="checkbox"/> SM400 <input type="checkbox"/> SM600	Must be completed to enroll:	Facility # - 1 st Choice	Facility # - 2 nd Choice
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Dependent Information: Select up to 3 dentists, 3 orthodontists and 1 vision care provider per family

	Last Name	First Name	MI	Sex	Birthdate	Facility # - 1 st Choice	Facility # - 2 nd Choice
Spouse							
Child #1							
Child #2							
Child #3							
Child #4							

Must be completed to enroll in plan(s)

Step 1. Select a rate	Step 2. Select a payment option
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Annual Rates:

Dental	SM400	SM600
Subscriber Only	\$ 192.96	\$ 69.96
Subscriber + One	\$ 288.96	\$ 114.96
Subscriber + Family	\$ 397.92	\$ 141.00

One-time application fee (non-refundable) +\$16.00

Total Amount \$ _____

Monthly Rates:

Dental	SM400	SM600
Subscriber Only	\$ 17.00	\$ 6.65
Subscriber + One	\$ 25.20	\$ 10.40
Subscriber + Family	\$ 34.50	\$ 13.00

One-time application fee (non-refundable) +\$16.00

Total Amount \$ _____

Annual by check made payable to SmileSaver (include with application)

Monthly by credit card **Annual by credit card**

Please charge my: VISA MasterCard Discover American Express

Credit Card Number Expiration Date CID #

_____ / _____

Name as it appears on credit card: _____

I hereby authorize credit card payment in the amount indicated on this application:

Signature: _____ Date: _____

Monthly by checking account (Include check for first month's payment. This is the account number we will use for your monthly bank debit.)

Automatic Bank Account payments are deducted on or about the 20th of each month.

I hereby authorize SafeGuard Health Plans, Inc., to debit the designated prepayment fee each month from my bank account. This authorization will remain in effect until I notify SafeGuard, in writing, 30 days prior to termination. My bank is authorized to make any necessary corrections.

Signature: _____ Date: _____

Use and Disclosure of Personal Health Information:
Agreement - I understand that any dispute or controversy which may arise between SafeGuard Health Plans, Inc., a California Corporation and myself, may be submitted to binding arbitration in lieu of a jury or court trial.

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 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 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 understand that the initial term of the plan contract is for one year. **Mail this application to:** SmileSaver - DAIS
3720 S. Susan St. #200
Santa Ana, CA 92704

Signature: _____ Date: _____

Visit SafeGuard's website at www.safeguard.net for current provider listings
SmileSaver_{sm} Dental & Vision products are provided by SafeGuard Health Plans, Inc.