SafeGuard Meridian Dental Enrollment Form
Texas

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

Please Print	Last Name	First Name	MI	Male/ Female	Date of Birth		
					Mo.	Day	Year
Spouse							
Child							
-							
-							
-							
-							

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

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

☐ I hereby apply to SafeHealth Life Insurance for Group Dental Insurance as presented to me and authorize my employer to make any necessary deduction from my salary to pay the premium when my insurance becomes effective.

Your Name (Please Print)	Your Signature	Date

Waiver of Coverage

I have been given the opportunity to apply for group dental insurance, but:

☐ Do not choose to elect this coverage.

☐ Am covered under spouse's dental plan with _____
Name of Insurance Company

Visit our website at www.safeguard.net for up-to-date provider listings.