# CHOICEPLUS offered by SafeGuard® Employee Enrollment Form

| Office Use Only | Plan: | Account Number: | Member Number: | Code: |
|---|---|---|---|---|
| | | | | |

- If you wish to refuse coverage for yourself or a dependent, please complete the waiver at the bottom of the page -

**EMPLOYER SECTION**

| Please check one box only | Effective Date: | Name of Company: | Account Number: |
|---|---|---|---|
| ❑ Initial request<br>❑ Request to add dependent(s)<br>❑ Open enrollment | ___/____/_____<br>mm dd yyyy | | |

• Please print all information • Sign and date this form below •

**EMPLOYEE SECTION**

| Employee Name: (last) (first) (middle initial) | Social Security#: |
|---|---|
| | |

Home Address: (street) (city) (state) (zip)

| Date of Birth: / / | Age: | ❑ Female ❑ Male | Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner ❑ Eligible Children: _____ |
|---|---|---|---|
| Date of Hire: / / | Total hours worked per week: ❑ Less than 30 ❑ More than 30 | | |
| Occupation:_____ | | | |

**PLAN SELECTION**

| | | |
|---|---|---|
| ❑ Dental HMO | ❑ Dental PPO/Indemnity<br>❑ Dental HMO Ortho (optional)<br>❑ Indemnity Ortho | ❑ Indemnity Vision<br>❑ SM10<br>❑ SM20/20<br>❑ SM30 |

**ENROLLEE INFORMATION**

Please provide all information for each person to be enrolled.

| LAST NAME FIRST NAME | SEX | BIRTHDATE | FULL-TIME STUDENT* | SOCIAL SECURITY # | SEE PROVIDER DIRECTORY FOR I.D. CODES: DENTAL CODE | ORTHO CODE | VISION CODE |
|---|---|---|---|---|---|---|---|
| self - - - - - - - EMPLOYEE - - - - - - - | | / / | N/A | - - | | | |
| spouse | | / / | N/A | - - | | | |
| child | | / / | | - - | | | |
| child | | / / | | - - | | | |
| child | | / / | | - - | | | |
| child | | / / | | - - | | | |
| child | | / / | | - - | | | |
| child | | / / | | - - | | | |

* For all dependents age 19 or older, please provide proof that they are a full time student.

*I hereby declare that I am a full-time employee of the employer indicated above and that I regularly work at least 30 hours per week at or from the employment location indicated. I hereby request the group insurance for which I am or may become eligible under the policies issued to the Trustee of the National Group Trust by the Insurance Company. I authorize the deductions from my earnings of any contributions I may have to make toward the cost. I understand that my request for group insurance shall include this form and any part or parts of the Supplement to Request for Group Insurance (Health Statement) which may be required. All information given by me on this form is true and complete and is offered as an inducement to grant insurance coverage.*

Employee's Signature: _____ Date: _____

*Dental & Vision HMO benefits provided by SmileSaver, a division of SafeGuard Health Plans, Inc.*
*Indemnity, PPO, and Indemnity Vision insured by Security Life Insurance Company of America, Minnetonka, MN.*

## Waiver

Complete this section only if you are refusing dental coverage for yourself or a dependent. Then sign, date and return this form to your employer.

Waiver

Refusing coverage for: ❑ Self ❑ Spouse ❑ Child(ren)

Reason for refusal: ❑ Covered under spouse's group insurance plan. Name of plan: _____
❑ Other/Explain: _____

*I understand that if I later wish to enroll or re-enroll, I must provide satisfactory evidence of insurability to the Insurance Company or be subject to limited benefits for a specified period of time. I also understand that I may not be eligible for all plans made available through National Group Trust.*

Employee's Name (Print): _____ Company Name: _____

Employee's Signature: _____ Date: _____