



Benefits provided by SafeGuard Health Plans, Inc.
 A MetLife company
 95 Enterprise, Suite 200
 Aliso Viejo, CA 92656-2611

ENROLLMENT FORM FOR GROUP DHMO BENEFITS

Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator. Choose a general dental office (facility number) of your choice for each eligible family member from the SafeGuard Directory of Participating Dentists. Failure to do so may result in delays in receiving dental care. If your first provider facility selection is not available, SafeGuard will process your second selection.

SECTION TO BE COMPLETED BY BENEFITS COORDINATOR

Name of Group/Employer (Please Print)	Group No.	Division/Sub Code	Class/Branch Code	Dept Code
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			
Original COBRA Effective Date if applicable (MM/DD/YYYY)	COBRA Termination Date if applicable (MM/DD/YYYY)			

SECTION TO BE COMPLETED BY MEMBER/EMPLOYEE

Name (First, Middle, Last)	Social Security No.	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married
Address (Street, City, State, Zip Code)		Date of Birth (Mo./Day/Yr.)	
<input type="checkbox"/> Employee <input type="checkbox"/> Retired	Job Title:	Hours Worked Per Week:	
<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment <input type="checkbox"/> COBRA Continuation If due to a Qualifying Event, enter date (MM/DD/YYYY)			
E-mail Address		Phone No. (include area code)	

SELECT A SELECTED GENERAL DENTAL OFFICE: MUST BE COMPLETED TO ENROLL IN PLAN:

Failure to select a Selected General Dental Office may result in delays in receiving dental benefits. If your first facility selection is not available, We will process your second selection. Facility numbers are found next to each Selected General Dental Office's name in the Directory of Participating Dentists.	Facility Number - 1st Choice:
	Facility Number - 2nd Choice:

<p>COVERAGE REQUEST DATA: I have received and read a copy of the group/employer's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.</p> <p>I request the following coverage:</p> <p>Member/Employee Coverage <input type="checkbox"/> Dental</p> <p>Spouse/Domestic Partner Coverage <input type="checkbox"/> Dental</p> <p>Dependent Child Coverage <input type="checkbox"/> Dental</p>	<p>If applying for Dependent coverage (Spouse/Domestic Partner and Child), complete section below:</p> <p>Choose a Selected General Dental Office (facility number) of your choice for each eligible family member from the Directory of Participating Dentists.</p> <p>Number of Dependents (including Spouse/Domestic Partner):</p> <table border="1"> <thead> <tr> <th>Name (First, Middle, Last)</th> <th>Date of Birth (MM/DD/YYYY)</th> <th>Sex (M/F)</th> <th>Facility 1st</th> <th>Facility 2nd</th> </tr> </thead> <tbody> <tr> <td>Spouse /Domestic Partner: _____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Child(ren): _____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Sex (M/F)	Facility 1 st	Facility 2 nd	Spouse /Domestic Partner: _____	_____	_____	_____	_____	Child(ren): _____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Sex (M/F)	Facility 1 st	Facility 2 nd																						
Spouse /Domestic Partner: _____	_____	_____	_____	_____																						
Child(ren): _____	_____	_____	_____	_____																						
_____	_____	_____	_____	_____																						
_____	_____	_____	_____	_____																						

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by SafeGuard to determine his or her eligibility.

For Changes Requested After Initial Enrollment Period Expires. I understand that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization By the Member/Employee. If this group coverage is provided through my employer, I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

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

Authorization to release dental 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 General Dentist and/or Specialty Care Dentist, 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.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application for benefits or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Point of service option: MetLife does not offer a Point-of-Service option in the state of Texas.

Signature(s): The member/employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Member/Employee Signature

Print Name

Date (Mo./Day/Yr.)



Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- process claims and other transactions
- perform business research
- confirm or correct your information
- market new products to you
- help us run our business
- comply with applicable laws

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits

- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long-term care, or medical insurance from us, the Health Insurance Portability and Accountability Act (“HIPAA”) may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

Metropolitan Life Insurance Company
General American Life Insurance Company
SafeHealth Life Insurance Company

MetLife Insurance Company of Connecticut
SafeGuard Health Plans, Inc.

Language Assistance

As a SafeGuard member you have a right to free language assistance services, including interpretation and translation services. SafeGuard collects and maintains your language preferences, race, and ethnicity so that we can communicate more effectively with our members. If you require spoken or written language assistance or would like to inform SafeGuard of your preferred language, please contact us at (800) 880-1800.

Como miembro de SafeGuard, tiene derecho a servicios gratuitos de ayuda con idiomas, que incluyen servicios de interpretación y traducción. SafeGuard recopila y conserva sus preferencias de idioma, raza y origen étnico para poder comunicarnos más eficazmente con nuestros miembros. Si necesita ayuda oral o escrita con un idioma, o si desea informar a SafeGuard su idioma de preferencia, comuníquese con nosotros al (800) 880-1800.

作為 SafeGuard 的會員，您有權享受免費語言協助服務，包括口譯及翻譯服務。SafeGuard 將搜集並保留您的語言偏好、種族及民族的相關資料，以便於我們更有效地與會員溝通。如需口頭或書面語言協助，或樂意告知 SafeGuard 您的首選語言，請致電(800) 880-1800 聯絡我們。