



Powered by SafeGuard

Initial Application

**APPLICATION & ACKNOWLEDGEMENT
GROUP DENTAL INSURANCE BENEFITS**

Organization Policyholder Name (full legal name)	Group No.

Organization is a
 Corporation Partnership Sole Proprietor Government Agency Union Trust

Street / P.O. Box Number

City:	State:	Zip:
	CA	

Telephone	Fax
()	()

Contact	Contact Title	Contact Telephone
		()

Plan Selected:
 250 Ded with Ortho 250 Ded without Ortho 500 Ded with Ortho 500 Ded without Ortho

Effective Date
 SAFEHEALTH, subject to all the conditions and provisions of the POLICY, and in reliance upon the statements of each Enrollee of the Organization in his or her Enrollment Card, shall provide the services and benefits and the other rights and privileges which are set forth in the POLICY, which shall take effect on ____/____/____, the "Effective Date", and shall continue for the terms of this policy.

Eligibility

List Current Dental Carrier(s): _____ Years with Carrier: _____

Type of Business: _____

List Current Workers' Compensation Carrier: _____

Number of permanent full-time (30+ hours per week) employees: _____

Number of eligible employees waiving dental coverage: _____

Please complete if offering dental coverage to permanent part-time (at least 20 but less than 29 hours per week) employees

Number of permanent part-time employees: _____

Classes of employees to be covered: All Employees Union Salaried Non-Union

Contribution

_____ % of employee premium _____ % of dependent premium

Waiting Period
 All employees are to eligible on the effective date except part-time (unless specified above) and disabled employees. Employees who commence work after the effective date, shall be eligible on the first of the month following completion of _____ days of continuous active employment.

If employer is multi-site, please note name and address of any subsidiary or affiliated companies to be included under the POLICY on the reverse of this Agreement. Formal documents govern all rights and benefits; for full and complete policy information, please refer to your Master Policy. If any of Organization's locations are to be excluded from the POLICY, please note name and address in the appropriate area below.

If group is multi-site, locations to be covered under the POLICY (must have been included in underwriting process)

If group is multi-site, locations to be excluded under the POLICY (must NOT have been included in underwriting process)

It is understood that no person, except an authorized Officer of SafeHealth Life Insurance Company, has the authority to modify, enlarge or vary and policy or to waive any requirement in any policy.

\$ _____ is submitted with this Application Agreement to be applied toward the first month's premium.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Organization

Dated at _____ this _____ day of _____ , _____

Organization _____ Tax I.D. # _____

Authorized Organization Representative _____
(please print)

Signature _____ Title _____

Broker Information

Broker Name _____ Broker License # _____

Street Address _____ City _____ State _____ Zip _____

Signature _____ Date _____

SafeHealth Life Insurance Company

Dated at _____ Aliso Viejo, CA _____ this _____ day of _____ , _____

SafeHealth Life Insurance Company Representative _____ Robin Muck _____
(please print)

Signature _____ Title _____ Vice President _____



EMPLOYER BENEFIT AUTHORIZATION – SAFEGUARD DENTAL

Employer Name:			
Contact Name:		Principle Name:	
Plan Name:		Principle Title:	
Effective Date:		Federal Tax ID #	

IN-NETWORK / OUT-OF-NETWORK BENEFIT DESIGN

Plan Selected	<input type="checkbox"/> 250 Ded with Ortho	<input type="checkbox"/> 250 Ded w/o Ortho	<input type="checkbox"/> 500 Ded with Ortho	<input type="checkbox"/> 500 Ded w/o Ortho
EE Deductible (Circle One) 2x Family	\$0 \$25 \$50 \$100 Other:	\$0 \$25 \$50 \$100 Other:	\$0 \$25 \$50 \$100 Other:	\$0 \$25 \$50 \$100 Other:
Preventive Benefits	100% Other:	100% Other:	100% Other:	100% Other:
Basic	80% Other:	80% Other:	80% Other:	80% Other:
Major	50% Other:	50% Other:	50% Other:	50% Other:
Ortho	50% Other:	N/A	50% Other:	N/A

THREE(3) SIMPLE CHECKS TO GET YOUR NEW PLAN STARTED

Check One -	Check payable to Safeguard. This check will need to include; Safeguard Premium, Employees Administrative Fee, and \$25 flat monthly fee.		
Check Two -	Check payable to Ben-e-lect for the Set Up Fee of \$250. (One time fee)		
Check Three -	Check payable to Employer Elect. Follow the simple formula below for the suggested Claims Deposit Amount.		
	Current Monthly Premium		\$
		(-) minus	
	New Monthly Premium		\$
		(-) minus	
	Monthly Administrative Fee		\$
		(=) equals	
	Subtotal		\$
		(x2) times 2	
	Deposit Amount (min \$1,000)		\$

There is a monthly PEPM administrative fee (see your proposal or agent for details); there is a one-time set up fee of \$250 to start the Ben-e-lect plan. Additionally, there is a \$100 renewal fee that will be charged at the end of each year.

Please complete all of the information requested before signing this authorization. Please initial any changes. This is an application only. Coverage and the issuance of an Administrative Agreement are subject to review and approval by Ben-e-lect.

Officer of the Company's Signature:		DATE:
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