

NATIONAL ASSOCIATION FOR MEDICAL & DENTAL, INC.

Membership Enrollment Form - NA245D

Last Name:		First Name:		M.I.:	Social Security Number:	
Home Address:			City (Complete Name):		State:	Zip Code:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth: Month Day Year		Home Phone: () ()		Work Phone: () ()
Spouse/Child		Male/Female		Last Name		First Name
						M.I.
						Date of Birth

Please select your payment option (annual or monthly) and provide the necessary information.

Monthly Payment - Draft Date (choose one):		<input type="checkbox"/> 1st	<input type="checkbox"/> 10th	<i>of each month.</i>	
By Automatic Bank Account Draft: <input type="checkbox"/> Checking Account <input type="checkbox"/> Savings Account <input type="checkbox"/> Credit Card <input type="checkbox"/> SIC					
Bank Name:			<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Discover		
Branch Routing Number:			<input type="checkbox"/> American Express		
Account Number:			Card #: _____		
			Expiration Date: _____		
			Card Holder: _____		
PLEASE CHECK ONE OF THE FOLLOWING					3 Digit Code _____
<input type="checkbox"/> Subscriber Only \$39.95	<input type="checkbox"/> Subscriber and One Dependant \$57.95	<input type="checkbox"/> Subscriber and Family \$79.95	<input checked="" type="checkbox"/> One Time Enrollment Fee \$55.00 <small>(To Be Included In Check)</small>		
TOTAL AMOUNT OF ENCLOSED CHECK: \$					
I UNDERSTAND THAT THE INITIAL TERM OF MY GROUP MEMBERSHIP CONTRACT IS FOR 6 MONTHS. I HEREBY AUTHORIZE HCNM, INC. TO DEBIT THE BANK ACCOUNT OR CREDIT CARD EACH MONTH AS NOTED ABOVE. I UNDERSTAND THAT THE AMOUNT OF MY MONTHLY PREMIUM WILL BE DEDUCTED FROM MY ACCOUNT.					
Signature: X			Date:		

Annual Payment					
PLEASE CHECK ONE OF THE FOLLOWING					
<input type="checkbox"/> Subscriber Only \$479. ⁴⁰	<input type="checkbox"/> Subscriber and One Dependant \$695. ⁴⁰	<input type="checkbox"/> Subscriber and Family \$959. ⁴⁰	<input type="checkbox"/> One Time Enrollment Fee \$55.00 <small>(To Be Included In Check)</small>		
TOTAL AMOUNT OF ENCLOSED CHECK: \$					
Make Checks Payable To:					
HCNM INC.			Please Fax Enrollment Form To: 407-218-8943 For Assistance Call (407) 844-4719		

Enrollers Name _____ # _____



SafeGuard

Dental HMO Enrollment Form Texas

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.

Benefits Coordinator Use Only

Group/Employer Name	Group No. 5752196	Effective Date	Date of Hire
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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.
Must be completed to enroll in plan:				Facility Number - 1st Choice		Facility Number - 2nd Choice

Facility numbers are found next to each General Dentist's name in the SafeGuard Directory of Participating Dentists and on our website at www.safeguard.net.

Dependent Information

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	Facility Number 1st Choice	Facility Number 2nd Choice
Please indicate any disability that would affect your ability to communicate or read: _____								Must be completed to enroll in plan	

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 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.

Point of service option: SafeGuard has arranged for indemnity insurance coverage to be provided to eligible members for services not supplied by SafeGuard. This arrangement is a benefit under the terms of this contract, and the Certificate of Insurance issued by SafeHealth Life Insurance Company, which outlines the scope of coverage and the manner in which the dental insurance coverage may be used.

In order to receive benefits from SafeGuard Health Plans' Dental HMO Plan, you must utilize only network providers, except for emergency dental care, and pay the co-payments specified in the Evidence of Coverage. Under the indemnity policy, you may utilize and provider but prior to receiving reimbursement, your must meet the required deductible and are responsible for the co-insurance amount specified in the policy or certificate.

I choose to elect the Point-of-Service Option.

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

Waiver of Coverage

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

Do not choose to elect this coverage.

Your Name (Please Print)	Your Signature	Date