



Safeguard HMO Dental Plan

Payrolling.com is pleased to offer you participation in the Safeguard HMO Dental Plan. Below is some important information to know about the plan. If you have any questions, please do not hesitate to contact your Benefits Administrator at:

858-866-2600 or benefits@payrolling.com

Important Plan Information

- The effective date for your coverage will be the first of the month after 30 days of employment.
- Employees working 20 or more hours per week are eligible.
- If you do not submit your application by the above deadline, you may not enroll until the next Open Enrollment period or if you experience a Family Status Change (marriage, divorce, birth of a child, spouse's job change, etc.). You have 30 days from the event to update your coverage. Documentation will be required.
- Changes or cancellation of your coverage can only occur during the annual Open Enrollment period or if you experience a Family Status Change. Adjustments relating to a Family Status Change must be made within 30 days of the event. Documentation will be required.
- Deductions for your coverage will be taken per paycheck on a pre-tax basis unless you notify us, in writing, otherwise.
- Please review the plan documents carefully. If you have any questions on the coverage, contact the Payrolling.com Benefits Department.

Rates*

Safeguard Dental HMO (California only)

Employee	\$3.50 per week
Employee +1	\$6.84 per week
Family	\$9.17 per week

Instructions for completing the HMO application:

- Complete the application labeled HMO. Be certain to include a Primary Care Dentist. You can search for a dentist at www.safeguard.net. Select plan Excel 2004.

Fax completed application to the Payrolling.com Benefits Department at: 858-866-2601.

*Amounts listed are based on a weekly pay cycle. If you are paid bi-weekly, semi-monthly, or monthly, your deductions will be adjusted accordingly.



DIRECT REFERRAL DENTAL PLAN*

EXCEL 3004 - PREPAID DENTAL PLAN

SCHEDULE OF BENEFITS

This schedule describes the services available to you and the co-payments and other fees associated with those services. There are certain other factors that impact how your plan is administered; they are outlined in the Exclusions & Limitations found at the end of this document.

During the course of treatment, your SafeGuard selected general dentist may recommend the services of a dental specialist.

*Your SafeGuard selected general dentist is responsible for coordinating your dental care, and if necessary, referring you to a SafeGuard contacted specialist, and will submit all required documentation to SafeGuard for any necessary referral.

Benefits provided by SafeGuard Health Plans, Inc.

Code	Service	Co-payment
Diagnostic Treatment		
D0120	Periodic oral evaluation – established patient	\$0
D0140	Limited oral evaluation – problem focused	\$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	\$0
D0150	Comprehensive oral evaluation – new or established patient	\$0
D0180	Comprehensive periodontal evaluation – new or established patient	\$0
Radiographs/Diagnostic Imaging (X-rays)		
D0210	Intraoral – complete series (including bitewings) (1 in 3 years)	\$0
D0220	Intraoral – periapical first film	\$0
D0230	Intraoral – periapical each additional film	\$0
D0240	Intraoral – occlusal film	\$0
D0250	Extraoral – first film	\$0
D0260	Extraoral – each additional film	\$0
D0270	Bitewing – single film	\$0
D0272	Bitewings – two films	\$0
D0273	Bitewings – three films	\$0
D0274	Bitewings – four films	\$0
D0277	Vertical bitewings – 7 to 8 films	\$0
D0330	Panoramic film	\$18
D0340	Cephalometric film	\$0
D0350	Oral/facial photographic images	\$0
Tests and Examinations		
D0460	Pulp vitality tests	\$0
D0470	Diagnostic casts	\$0

Code Service Co-payment

Preventive Services

Procedures identified with an asterisk () are limited to twice a year, unless medically necessary.*

D1110	Prophylaxis – adult*	\$0
D1120	Prophylaxis – child*	\$0
	<i>Prophylaxis: Cleaning</i>	
D1203	Topical application of fluoride (prophylaxis not included) – child*	\$0
D1204	Topical application of fluoride (prophylaxis not included) – adult*	\$0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients*	\$0
D1310	Nutritional counseling for control of dental disease	\$0
D1320	Tobacco counseling for the control and prevention of oral disease	\$0
D1330	Oral hygiene instructions	\$0
D1351	Sealant – per tooth	\$6
D1510	Space maintainer – fixed – unilateral	\$20
D1515	Space maintainer – fixed – bilateral	\$20
D1520	Space maintainer – removable – unilateral	\$20
D1525	Space maintainer – removable – bilateral	\$20
D1550	Recementation of space maintainer	\$10
D1555	Removal of fixed space maintainer	\$10

Restorative Treatment

D2140	Amalgam – one surface, primary or permanent	\$0
D2150	Amalgam – two surfaces, primary or permanent	\$0
D2160	Amalgam – three surfaces, primary or permanent	\$0
D2161	Amalgam – four or more surfaces, primary or permanent	\$0
	<i>Amalgam: Silver fillings</i>	
D2330	Resin-based composite – one surface, anterior	\$0
D2331	Resin-based composite – two surfaces, anterior	\$0
D2332	Resin-based composite – three surfaces, anterior	\$0
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	\$0
D2391	Resin-based composite – one surface, posterior	\$45
D2392	Resin-based composite – two surfaces, posterior	\$60
D2393	Resin-based composite – three surfaces, posterior	\$75
D2394	Resin-based composite – four or more surfaces, posterior	\$90
	<i>Resin-based composite: White fillings</i>	

Crowns

- Replacement limit 1 every 5 years.
 - An additional charge will be applied for any procedure using noble or high noble metal.
 - Cases involving 7 or more crowns in the same treatment plan require a \$125 member fee per unit in addition to co-payment.
 - \$75 fee per crown unit above co-payment for porcelain on molars.
- | | | |
|-------|---|-------|
| D2510 | Inlay – metallic – one surface | \$150 |
| D2520 | Inlay – metallic – two surfaces | \$175 |
| D2530 | Inlay – metallic – three or more surfaces | \$200 |
| D2543 | Onlay – metallic – three surfaces | \$225 |
| D2544 | Onlay – metallic – four or more surfaces | \$250 |
| D2740 | Crown – porcelain/ceramic substrate | \$165 |
| D2750 | Crown – porcelain fused to high noble metal | \$165 |
| D2751 | Crown – porcelain fused to predominantly base metal | \$165 |
| D2752 | Crown – porcelain fused to noble metal | \$165 |
| D2780 | Crown – ¾ cast high noble metal | \$150 |
| D2781 | Crown – ¾ cast predominantly base metal | \$150 |

Code	Service	Co-payment
D2782	Crown – ¾ cast noble metal	\$150
D2783	Crown – ¾ porcelain/ceramic	\$165
D2790	Crown – full cast high noble metal	\$150
D2791	Crown – full cast predominantly base metal	\$150
D2792	Crown – full cast noble metal	\$150
D2794	Crown – titanium	\$165
D2910	Recement inlay, onlay, or partial coverage restoration	\$10
D2915	Recement cast or prefabricated post and core	\$10
D2920	Recement crown	\$10
D2930	Prefabricated stainless steel crown – primary tooth	\$10
D2931	Prefabricated stainless steel crown – permanent tooth	\$15
D2940	Sedative filling	\$7
D2950	Core buildup, including any pins	\$5
D2951	Pin retention – per tooth, in addition to restoration	\$3
D2952	Post and core in addition to crown, indirectly fabricated	\$40
D2954	Prefabricated post and core in addition to crown	\$20
D2955	Post removal (not in conjunction with endodontic therapy)	\$12
D2970	Temporary crown (fractured tooth)	\$0

Endodontics

All procedures exclude final restoration.

D3110	Pulp cap – direct (excluding final restoration)	\$0
D3120	Pulp cap – indirect (excluding final restoration)	\$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	\$0
D3221	Pulpal debridement, primary and permanent teeth	\$0
D3310	Anterior (excluding final restoration) - per tooth	\$70
D3320	Bicuspid (excluding final restoration) - per tooth	\$105
D3330	Molar (excluding final restoration) - per tooth	\$135
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$50
D3346	Retreatment of previous root canal therapy – anterior - per tooth	\$70
D3347	Retreatment of previous root canal therapy – bicuspid- per tooth	\$105
D3348	Retreatment of previous root canal therapy – molar - per tooth	\$135
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$100
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$100
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	\$100
D3410	Apicoectomy/periradicular surgery – anterior	\$200
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	\$200
D3425	Apicoectomy/periradicular surgery – molar (first root)	\$200
D3426	Apicoectomy/periradicular surgery (each additional root)	\$100
D3430	Retrograde filling – per root	\$125
D3450	Root amputation – per root	\$275
D3920	Hemisection (including any root removal), not including root canal therapy	\$115

Periodontics

D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	\$35
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	\$26
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	\$325

Code	Service	Co-payment
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	\$245
D4249	Clinical crown lengthening – hard tissue	\$300
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	\$225
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	\$170
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	\$45
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	\$34
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$15
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$55
D4910	Periodontal maintenance (2 in a 12 month period)	\$10
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$0

Removable Prosthodontics

- Replacement limit 1 every 5 years.
- Includes up to 3 adjustments within 6 months of delivery.
- Denture relines: Twice in one year

D5110	Complete denture – maxillary	\$150
D5120	Complete denture – mandibular	\$150
D5130	Immediate denture – maxillary	\$150
D5140	Immediate denture – mandibular	\$150
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$150
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$150
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$180
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$180
D5410	Adjust complete denture – maxillary	\$10
D5411	Adjust complete denture – mandibular	\$10
D5421	Adjust partial denture – maxillary	\$10
D5422	Adjust partial denture – mandibular	\$10
D5510	Repair broken complete denture base	\$10
D5520	Replace missing or broken teeth – complete denture (each tooth)	\$10
D5610	Repair resin denture base	\$10
D5620	Repair cast framework	\$10
D5630	Repair or replace broken clasp	\$10
D5640	Replace broken teeth – per tooth	\$10
D5650	Add tooth to existing partial denture	\$10
D5660	Add clasp to existing partial denture	\$10
D5710	Rebase complete maxillary denture	\$125
D5711	Rebase complete mandibular denture	\$125
D5720	Rebase maxillary partial denture	\$125
D5721	Rebase mandibular partial denture	\$125
D5730	Reline complete maxillary denture (chairside)	\$20
D5731	Reline complete mandibular denture (chairside)	\$20
D5740	Reline maxillary partial denture (chairside)	\$20
D5741	Reline mandibular partial denture (chairside)	\$20
D5750	Reline complete maxillary denture (laboratory)	\$50
D5751	Reline complete mandibular denture (laboratory)	\$50

Code	Service	Co-payment
D5760	Reline maxillary partial denture (laboratory)	\$50
D5761	Reline mandibular partial denture (laboratory)	\$50
D5820	Interim partial denture (maxillary)	\$75
D5821	Interim partial denture (mandibular)	\$75
D5850	Tissue conditioning, maxillary	\$75
D5851	Tissue conditioning, mandibular	\$75

Crowns/Fixed Bridges - Per Unit

- Replacement limit 1 every 5 years.
- An additional charge will be applied for any procedure using noble or high noble metal.
- Cases involving 7 or more crowns in the same treatment plan require a \$125 member fee per unit in addition to co-payment.
- \$75 fee per crown unit above co-payment for porcelain on molars.

D6210	Pontic – cast high noble metal	\$150
D6211	Pontic – cast predominantly base metal	\$150
D6212	Pontic – cast noble metal	\$150
D6214	Pontic – titanium	\$165
D6240	Pontic – porcelain fused to high noble metal	\$165
D6241	Pontic – porcelain fused to predominantly base metal	\$165
D6242	Pontic – porcelain fused to noble metal	\$165
	<i>Pontic: Artificial tooth on denture or bridge</i>	
D6750	Crown – porcelain fused to high noble metal	\$165
D6751	Crown – porcelain fused to predominantly base metal	\$165
D6752	Crown – porcelain fused to noble metal	\$165
D6780	Crown – ¾ cast high noble metal	\$150
D6781	Crown – ¾ cast predominantly base metal	\$150
D6782	Crown – ¾ cast noble metal	\$150
D6790	Crown – full cast high noble metal	\$150
D6791	Crown – full cast predominantly base metal	\$150
D6792	Crown – full cast noble metal	\$150
D6794	Crown – titanium	\$165
D6930	Recement fixed partial denture	\$10
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$40
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$20
D6973	Core build up for retainer, including any pins	\$25

Oral Surgery

- Includes routine post operative visits/treatment.
- Surgical removal of impacted teeth - not covered unless pathology [disease] exists.
- Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.

D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$5
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$15
D7220	Removal of impacted tooth – soft tissue	\$35
D7230	Removal of impacted tooth – partially bony	\$45
D7240	Removal of impacted tooth – completely bony	\$60
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$60
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$15
D7280	Surgical access of an unerupted tooth	\$185
D7510	Incision and drainage of abscess – intraoral soft tissue	\$10
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$10

Code	Service	Co-payment
D7520	Incision and drainage of abscess – extraoral soft tissue	\$10
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	\$10
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	\$200
D7963	Frenuloplasty	\$200
D7971	Excision of pericoronal gingiva	\$40

Orthodontics

Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.

D8020	Limited orthodontic treatment of the transitional dentition (up to 24 months)	\$1,095
D8030	Limited orthodontic treatment of the adolescent dentition (up to 24 months)	\$1,095
D8040	Limited orthodontic treatment of the adult dentition (up to 24 months)	\$1,095
D8070	Comprehensive orthodontic treatment of the transitional dentition (full treatment case up to 24 months - including fixed/removable appliances)	\$1,995
D8080	Comprehensive orthodontic treatment of the adolescent dentition (full treatment case up to 24 months - including fixed/removable appliances)	\$1,995
D8090	Comprehensive orthodontic treatment of the adult dentition (full treatment case up to 24 months - including fixed/removable appliances)	\$1,995
D8660	Pre-orthodontic treatment visit	\$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	\$300
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers	\$0
D8999	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	\$200

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain – minor procedure	\$5
D9120	Fixed partial denture sectioning	\$0
D9215	Local anesthesia	\$0
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	\$55
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	\$5
D9440	Office visit – after regularly scheduled hours	\$25
D9630	Other drugs and/or medicaments, by report	\$15
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	\$0
D9951	Occlusal adjustment – limited	\$25
D9952	Occlusal adjustment – complete	\$350
D9972	External bleaching – per arch	\$200
D9973	External bleaching – per tooth	\$25
D9999	Broken appointment (less than 24 hour notice)	\$20

Current Dental Terminology © American Dental Association

Dental Terminology Definitions

These definitions are designed to give you a “layman’s understanding” of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam:	A silver filling
Anterior:	Teeth that are in the front of the mouth
Bicuspid:	Most people have eight bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.
Bridge:	A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).
Crown:	A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different materials (noble, high noble), base metal, porcelain or porcelain and metal.
Endodontics:	Procedures that treat the nerve or the pulp of the tooth due to injury or infection.
Oral Surgery:	Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.
Orthodontics:	Braces and other procedures to straighten the teeth.
Periodontics:	Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).
Posterior:	Teeth that set towards the back of the mouth, including molars and bicuspids (premolars).
Primary Teeth:	The first set of teeth (“baby” teeth).
Prophylaxis:	Scaling and polishing of teeth by removal of the plaque above the gum line.
Prosthodontics:	The restoration of natural and/or the replacement of missing teeth with artificial substitutes.
Quadrant:	One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).
Resin-based Composite:	Tooth-colored (white) fillings

Exclusions

1. Services performed by a general dentist or specialist, not contracted with SafeGuard without prior approval by SafeGuard, (except for out of area emergency services).
2. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member’s dental health, as determined by the SafeGuard contracted general dentist.
3. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
4. Dental procedures or services performed solely for cosmetic purposes or solely for appearance, except as noted within the Schedule of Benefits.
5. Orthognathic surgery.
6. General anesthesia or intravenous sedation.
7. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
8. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
9. Treatment of malignancies, cysts, or neoplasms.
10. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the *Schedule of Benefits*.
11. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
12. Precision attachments.
13. Dental procedures initiated prior to the member’s eligibility under this Plan or started after the member’s termination from the Plan.
14. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
15. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
16. Services considered unnecessary or experimental in nature.
17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.
18. Any dental procedure unable to be performed in the dental office due to the general health or physical limitations of the member including, but not limited to physical or emotional resistance, inability to visit the dental office, or allergy to commonly utilized local anesthetics.

Limitations

1. Cleanings (prophylaxis) and fluoride treatments are limited to 2 per 12 months, unless medically necessary.
2. An additional charge will be applied for any procedure using noble or high noble metal.
3. Denture relines are limited to twice in one year.
4. Full-mouth X-rays: Once every three (3) years unless medically necessary.
5. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard Benefit Plan. Replacements will be a benefit only if the existing denture is unsatisfactory and cannot be made satisfactory as determined by the SafeGuard contracted general dentist.

6. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
7. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
8. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require a \$125 co-payment per unit in addition to co-payments for each crown/bridge unit.
9. There is a \$75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
10. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.
11. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
12. Surgical removal of impacted teeth is not a covered benefit unless pathology disease exists.
13. The co-payments listed for endodontic procedures do not include the cost of final restoration.
14. Dentures (full or partial): Replacement only after five (5) years have elapsed following any provision of such dentures under a SafeGuard Benefit Plan.
15. Periodontal maintenance procedures (following active periodontal therapy) are limited to 2 in a 12-month period.

Orthodontic Exclusions & Limitations

1. Orthodontic treatment must be provided by a SafeGuard contracted general dentist or contracted specialty care provider in order for the co-payments listed in the *Schedule of Benefits* to apply.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of \$25 dollars.
3. The following are not included as orthodontic benefits:
 - A. Repair or replacement of lost or broken appliances;
 - B. Retreatment of orthodontic cases;
 - C. Treatment in progress at inception of eligibility;
 - D. Interceptive or phase I orthodontics;
 - E. Changes in treatment necessitated by an accident;
 - F. Treatment involving:
 1. Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
 2. Hormonal imbalances or other factors affecting growth or developmental abnormalities;
 3. Treatment related to temporomandibular joint disorders;
 4. Lingually placed direct bonded appliances and arch wires ("invisible braces"); and
 5. Functional appliances that are used in conjunction with fixed appliances.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

SafeGuard Dental HMO Enrollment Form

How to Enroll:

Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator or SafeGuard. Choose a general dental office (facility) 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.	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.
1st Choice Dental Office #				2nd Choice Dental Office #		

Dependent Information

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	1st Choice Dental Office #	2nd Choice Dental Office #

Primary language: _____ Please note any communication impairment: _____

Agreement - I understand that any dispute or controversy which may arise between SafeGuard and my Organization or between myself and SafeGuard Health Plans, Inc., must be submitted to binding arbitration in lieu of a jury or court trial. This may not apply in all states.

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.

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

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

