

SafeGuard Vision Enrollment Form for California

How to Enroll:

Please print clearly when completing the Enrollment Form and return it to your Benefits Coordinator or SafeGuard.

Benefits Coordinator Use Only

Group/Employer Name	Group No.	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.	

Check one:

<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Children	<input type="checkbox"/> Employee + Family	<input type="checkbox"/> Waive Coverage
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Dependent Information

Please Print	Last Name	First Name	MI	Male/ Female	Date of Birth		
					Mo.	Day	Year
Spouse							
Child							
-							
-							
-							

Primary language: _____ Please note any communication impairment: _____

Authorization to release vision records - I hereby authorize the release and disclosure to review, or to obtain a copy or, any and all vision records which pertain to me or any member of my family, maintained by my releasing Optometrist, to SafeGuard and/or any designated agent or representative for the purposes of vision treatment and/or care, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

I hereby apply to SafeHealth Life Insurance Company for vision coverage as presented to me.

Your Name (Please Print)	Your Signature	Date
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Waiver of Coverage

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

- Do not choose to elect this coverage.
- Am covered under spouse's vision plan with _____
Name of Insurance Company

