

# SafeGuard Vision Enrollment Form

**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 of 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.

**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.

I hereby apply to SafeHealth Life Insurance 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

