PAPER APPLICATION INSTRUCTIONS

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POLICY HOLDER INFORMATION

- LAST NAME/FIRST NAME/M.I. - Please print in all capital letters.
- SOCIAL SECURITY NUMBER – Required for a policy to be issued
- HOME ADDRESS/CITY/STATE - Please print in all capital letters.
- SEX
- DATE OF BIRTH
- DAYTIME PHONE #
- ALTERNATE PHONE #
- EMAIL ADDRESS -

DEPENDENT INFORMATION

- SPOUSE/CHILD - Please list each
- M/F – Male or Female - - Please circle appropriate option
- LAST NAME - All capital letters
- FIRST NAME – All capital letters
- M.I.
- D.O.B.

PAYMENT INFORMATION

- FUTURE MONTHLY PAYMENT -- date each month outside of initial payment
- AUTOMATIC DRAFTING INFO – Check appropriate box
  - CHECKING /SAVINGS ACCT
    - BANK NAME -
    - ROUTING NUMBER – First 9 digits found to the left on the bottom of a check
    - ACCOUNT NUMBER -
  - CREDIT CARD/DEBIT CARD
    - CARD NAME - VISA/MC/DISCOVER/AMEX (NO PREPAID CARDS)
    - CARD #
    - EXP DATE -
    - CARD HOLDER – Name as it appears on the card
    - CCV# - last 3 digits found at the end of the signature strip on back of card (AMEX - 4 digits on front of card)
    - SIGNATURE – Card Holders signature

SIGNATURE OF POLICY HOLDER

ENROLLERS NAME - AGENT NAME AND AGENT ID

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IS NECESSARY FOR FACILITY SELECTION AND SAFEGUARD METLIFE AGREEMENT

SOME FIELDS HAVE BEEN PRE POPULATED TO HELP MINIMIZE DUPLICATION

- LAST NAME
- FIRST NAME
- SOCIAL
- FACILITY – 1ST CHOICE – Your provider will be "1st choice"
- FACILITY – 2ND CHOICE – This field is made available should "first choice" not be available
- DEPENDENT INFORMATION
- SIGNATURE OF APPLICANT

NATIONAL ASSOCIATION FOR MEDICAL & DENTAL, INC.

Membership Enrollment Form NA245D

Last Name:	First Name:	M.I.	Social Security Number:

Home Address:	City:	State:	Zip Code:

Sex : ☐ Male ☐ Female	Date of Birth:	Daytime Phone: ( )	Alt. Phone ( )	Email:

Dependent	Sex	Last Name	First Name	M.I.	D.O.B.
Spouse	M / F				
Child	M / F				
Child	M / F				
Child	M / F				
Child	M / F				
Child	M / F				

Future Monthly Payment - Draft Date (choose one): ☐ 3rd ☐ 20th of each month.

Automatic Bank Draft: ☐ Checking Account ☐ Savings Account ☐ Debit Card ☐ Credit Card

Bank Name:

Bank Routing Number:

Account Number:

Card Name: _____

Card #: _____

Exp. Date: _____

Card Holder: _____

CCV#: _____

Signature: _____

☐ **Subscriber Only** **$39.95**	☐ **Subscriber and one Dependent** **$57.95**	☐ **Subscriber and Family** **$79.95**	☐ **One time Enrollment Fee $55.00** **(To be Included in Initial Payment)**

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: _____

Please mail application to:

National Association for Medical and Dental, Inc.
Administered by: Healthcare National Marketing, Inc.
5211 U.S. HWY 19, Suite 200, New Port Richey, FL 34652

ENROLLERS NAME_____ #_____

MetLife

SafeGuard Dental HMO Enrollment Form

Benefits provided by SafeGuard Health Plans, Inc., a MetLife company

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.	Effective Date	Date of Hire
National Assoc. for Medical & Dental	5752196		---
Employee's Occupation	**Division**	**Class**	**Dept. Code**
---------- N/A ----------	------	----	----

Subscriber's Information

Last Name	First Name	MI	Subscriber SS#
			- -

Home Address	Apt. #
SAME AS PAGE ONE	

City	State	Zip Code
SAME AS PAGE ONE	-----	-----

Male/Female	Date of Birth	Home Telephone	Work Telephone	Ext.
-----	------	( ) - SAME	( ) - SAME	

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.

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**

Must be completed to enroll in plan:

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., may 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.

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

"DHMO" is used to refer to "Specialized Health Care Service Plans"