Vision PPO Enrollment Form California

Complete and sign this form and return it to your Benefits Coordinator.

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.

Dependent Information

Spouse / Dependent	Last Name	First Name	MI	Male/ Female	Date of Birth		
					Mo.	Day	Year

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.

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.

Waiver of Coverage

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

☐ Do not choose to elect this coverage.

Your Name (Please Print)	Your Signature	Date

Underwritten by SafeHealth Life Insurance Company