

NATIONAL ASSOCIATION FOR MEDICAL & DENTAL, INC.

Membership Enrollment Form - NA245D

Last Name:		First Name:		M.I.:	Social Security Number:	
Home Address:			City (Complete Name):		State:	Zip Code:
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth: Month Day Year		Home Phone: ()	Work Phone: ()		Email:
Spouse/Child	Male/Female	Last Name	First Name	M.I.	Date of Birth	

Please select your payment option (annual or monthly) and provide the necessary information.

Monthly Payment - Draft Date (choose one):				<input type="checkbox"/> 1st	<input type="checkbox"/> 10th	<i>of each month.</i>
By Automatic Bank Account Draft:				<input type="checkbox"/> Checking Account	<input type="checkbox"/> Savings Account	<input type="checkbox"/> Credit Card SIC
Bank Name:				<input type="checkbox"/> Visa <input type="checkbox"/> MC <input type="checkbox"/> Discover <input type="checkbox"/> American Express		
Branch Routing Number:				Card #: _____		
Account Number:				Expiration Date: _____		
				Card Holder: _____		
PLEASE CHECK ONE OF THE FOLLOWING						3 Digit Code _____
<input type="checkbox"/> Subscriber Only \$39.95	<input type="checkbox"/> Subscriber and One Dependand \$57.95	<input type="checkbox"/> Subscriber and Family \$79.95	<input type="checkbox"/> One Time Enrollment Fee \$55.00 <small>(To Be Included In Check)</small>			
TOTAL AMOUNT OF ENCLOSED CHECK: \$						
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:		

Annual Payment						
PLEASE CHECK ONE OF THE FOLLOWING						
<input type="checkbox"/> Subscriber Only \$479. ⁴⁰	<input type="checkbox"/> Subscriber and One Dependand \$695. ⁴⁰	<input type="checkbox"/> Subscriber and Family \$959. ⁴⁰	<input type="checkbox"/> One Time Enrollment Fee \$55.00 <small>(To Be Included In Check)</small>			
TOTAL AMOUNT OF ENCLOSED CHECK: \$						
Make Checks Payable To:				Mail or Fax application to; Healthcare National Inc. 4613 US Hwy 19 New Port Richey, Fl 34652 Tel; 727 846-7164 Fax; 727 816-9057		
HCNM INC.						

Enrollers Name _____ # _____

SafeGuard Dental Plan Enrollment Form (Florida)

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 Name	Group No. 5752196	Effective Date	Date of Hire
Member's Occupation	Division	Class	Dept. Code

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.
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.

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.

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
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