SafeGuard

SAFEGUARD FOR INDIVIDUALS & FAMILIES
ENROLLMENT APPLICATION

Agent: 15507

☐ One (Myself): $11.95
☐ Annual: $143.40

☐ Two (Myself + one dependent): $22.00
☐ Annual: $264.00

☐ Three or more: $29.75
☐ Annual: $357.00

Social Security Number	**Last Name**	**First Name**	**MI**

Street Address

City	**State**	**ZIP Code**	**Telephone**

Date of Birth	**Male** ☐ **Female** ☐	**Primary Language**	**Please note any communication impairment**

1st Choice for dental office (enter number from Provider Directory):	**2nd Choice for dental office (enter number from Provider Directory):**

Dependent Information

Spouse/ Child	Male/ Female	Last Name	First Name	MI	Date of Birth	Student Y/N	Disability Y/N	1st Choice Dental Office #	2nd Choice Dental Office #

Payment must be included with this enrollment form. There are two forms of payment, please choose one.

1. ☐ **I want to pay by MONTHLY BANK DRAFT.** I agree to have the dental plan premium directly deducted from my ☐ **CHECKING** ☐ **SAVINGS** on or about the 15th of each month and sent to SafeGuard.

My account number is: _____

I understand that the amount of my monthly premium will be deducted from my account and that there will be a $15 service charge for any returned drafts.

Include a check for the first month's premium.

2. ☐ **I want to pay ANNUALLY by** ☐ **check** (Please make check payable to SafeGuard.)

☐ **by credit card** ☐ **Visa** ☐ **Mastercard** ☐ **American Express** ☐ **Discover**

Account No. _____ Expiration Date: _____

Name as it appears on the card: _____

I understand the terms and conditions of the plan and I hereby request the plan a one (1) year/12 month period.

AUTHORIZATION TO RELEASE DENTAL RECORDS - I hereby authorize the release and disclosure to review or to obtain a copy thereof, of any and all dental records which pertain to me, maintained by my SafeGuard selected general dentist and/or specialty care dentist to SafeGuard and/or any designated agent or representative for the purposes of dental treatment, care and for SafeGuard Quality Assessment and Utilization Reviews, which will be kept strictly confidential. This authorization shall remain valid for the term of this coverage.

Your signature: _____ *Today's Date:* _____

Mail this application to: SafeGuard
Attn: *Individual Sales*
P.O. Box 8095
Laguna Hills, CA 92654-8095

SafeGuard SCHEDULE OF BENEFITS

DENTAL HMO PLAN SG220D-IP-TX

This Schedule of Benefits lists the services available to you under your SafeGuard plan, as well as the co-payments associated with each service. There are other factors that impact how your plan works and those are included here in the Exclusions & Limitations. We have also added some dental terminology definitions to help you better understand your plan - these can be found at the back of this Schedule.

The following member co-payments apply when services are performed by a participating General Dentist. Specialty Referrals are available only when the procedure cannot be performed by the General Dentist due to the severity of the problem and only when referred by SafeGuard. If you are referred to a dentist whose practice is limited to specialty care, your co-payment will be 75% of the usual and customary charge for those services. See the Exclusions and Limitations section for asterisk (*) detail and more information.

Code	Service	Co-payment
Diagnostic Treatment		
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation - problem focused	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D9491	Office visit fee - per visit	$5
D0210	X-rays intraoral - complete series - including bitewings (once every 3 years)	$0
D0220	X-rays intraoral - periapical - first film	$0
D0230	X-rays intraoral - periapical - each additional film	$0
D0240	X-rays intraoral - occlusal film	$0
D0250	X-rays extraoral - first film	$0
D0260	X-rays extraoral - each additional film	$0
D0270	X-rays bitewing - single film	$0
D0272	X-rays bitewings - two films	$0
D0274	X-rays bitewings - four films	$0
D0330	X-rays panoramic film	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
Preventive Services		
Procedures identified with an asterisk (*) are limited to twice a year, unless medically necessary.		
D1110	Prophylaxis - adult*	$18
D1120	Prophylaxis - child*	$18
D1201	Topical application of fluoride (including prophylaxis) - child*	$18
D1203	Topical application of fluoride (excluding prophylaxis) - child*	$0
D1204	Topical application of fluoride (excluding prophylaxis) - adult*	$0
D1205	Topical application of fluoride (including prophylaxis) - adult*	$18
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$10
D1510	Space maintainer - fixed - unilateral	$65
D1515	Space maintainer - fixed - bilateral	$65
D1520	Space maintainer - removable - unilateral	$65
D1525	Space maintainer - removable - bilateral	$65
D1550	Recementation of space maintainer	$5

Code	Service	Co-payment
Restorative Treatment		
D2140	Amalgam - one surface, primary or permanent	$12
D2150	Amalgam - two surfaces, primary or permanent	$14
D2160	Amalgam - three surfaces, primary or permanent	$16
D2161	Amalgam - four or more surfaces, primary or permanent	$18
D2330	Resin-based composite - one surface, anterior	$17
D2331	Resin-based composite - two surfaces, anterior	$20
D2332	Resin-based composite - three surfaces, anterior	$25
D2335	Resin-based composite - four or more surfaces or involving incisal angle, anterior	$28
D2390	Resin-based composite crown, anterior	$30
D2391	Resin-based composite, one surface, posterior	$65
D2392	Resin-based composite, two surfaces, posterior	$75
D2393	Resin-based composite, three surfaces, posterior	$120
D2394	Resin-based composite, four or more surfaces, posterior	$120
Crowns		
• *Replacement limit 1 every 5 years.*		
• *Procedures identified by two asterisks (**) involve the additional cost of noble/ high noble metal.*		
• *Cases involving 7 or more crowns in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*		
• *$75 fee per crown unit above co-pay for porcelain on molars.*		
D2510	Inlay - metallic - one surface**	$185
D2520	Inlay - metallic - two surfaces**	$185
D2530	Inlay - metallic - three or more surfaces**	$185
D2543	Onlay - metallic - three surfaces**	$220
D2544	Onlay - metallic - four or more surfaces**	$220
D2740	Crown - porcelain/ceramic substrate	$240
D2750	Crown - porcelain fused to high noble metal**	$220
D2751	Crown - porcelain fused to predominantly base metal	$220
D2752	Crown - porcelain fused to noble metal**	$220
D2780	Crown - 3/4 cast high noble metal**	$220
D2781	Crown - 3/4 cast predominantly base metal	$220
D2782	Crown - 3/4 cast noble metal**	$220
D2790	Crown - full cast high noble metal**	$220
D2791	Crown - full cast predominantly base metal	$220
D2792	Crown - full cast noble metal**	$220
D2910	Recement inlay	$0
D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$50
D2931	Prefabricated stainless steel crown - permanent tooth	$50
D2940	Sedative filling	$0
D2950	Core build up, including any pins	$50
D2951	Pin retention - per tooth, in addition to restoration	$10
D2952	Cast post and core in addition to crown	$50
D2954	Prefabricated post and core in addition to crown	$50
D2955	Post removal (not in conjunction with endodontic therapy)	$10
Endodontics		
All procedures exclude final restoration		
D3110	Pulp cap - direct	$5
D3120	Pulp cap - indirect	$5

Code	Service	Co-payment
D3220	Therapeutic pulpotomy	$20
D3230	Pulpal therapy with resorbable filling - primary anterior tooth	$40
D3240	Pulpal therapy with resorbable filling - primary posterior tooth	$40
D3310	Root canal - anterior, per tooth	$125
D3320	Root canal - bicuspid, per tooth	$130
D3330	Root canal - molar, per tooth	$265
D3346	Retreatment of root canal - anterior, per tooth	$135
D3347	Retreatment of root canal - bicuspid, per tooth	$140
D3348	Retreatment of root canal - molar, per tooth	$275
D3351	Apexification/recalcification - initial visit	$65
D3352	Apexification/recalcification - interim visit	$65
D3353	Apexification/recalcification - final visit	$65
D3410	Apicoectomy/periradicular surgery - anterior	$120
D3421	Apicoectomy/periradicular surgery - bicuspid, 1st root	$120
D3425	Apicoectomy/periradicular surgery - molar, 1st root	$120
D3426	Apicoectomy/periradicular surgery - each additional root	$120
D3430	Retrograde filling - per root	$35
D3450	Root amputation - per root	$95
D3920	Hemisection - including root removal (excluding root canal therapy)	$90

Periodontics

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces - per quadrant	$135
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	$101
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$250
D4241	Gingival flap procedure, including root planing - one to three teeth - per quadrant	$188
D4249	Clinical crown lengthening - hard tissue	$125
D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or bounded teeth spaces - per quadrant	$250
D4261	Osseous surgery (including flap entry and closure) -one to three teeth, per quadrant	$188
D4270	Pedicle soft tissue graft procedure	$250
D4271	Free soft tissue graft procedure (including donor site surgery)	$250
D4273	Subepithelial connective tissue graft procedure	$300
D4274	Distal or proximal wedge procedure - separate procedure	$70
D4341	Periodontal scaling and root planing - four or more contiguous teeth or bounded teeth spaces - per quadrant	$50
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	$38
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$50
D4381	Localized site - specific therapy	$60
D4910	Periodontal maintenance procedures - following active therapy (2 in a 12 month period)	$30

Removable Prosthodontics

- *Replacement Limit 1 Every 5 years.*
- *Procedures identified with three asterisks (***) are limited to 1 every 24 months.*
- *Includes up to 3 adjustments within 6 months of delivery.*

D5110	Complete upper denture	$250
D5120	Complete lower denture	$250
D5130	Immediate upper denture	$250
D5140	Immediate lower denture	$250

Code	Service	Co-payment
D5211	Upper partial - resin base (including clasps, rests and teeth)	$375
D5212	Lower partial - resin base (including clasps, rests and teeth)	$375
D5213	Upper partial - cast metal base with resin saddles (including clasps, rests and teeth)	$400
D5214	Lower partial - cast metal base with resin saddles (including clasps, rests and teeth)	$400
D5410	Adjust complete denture - upper	$10
D5411	Adjust complete denture - lower	$10
D5421	Adjust partial denture - upper	$10
D5422	Adjust partial denture - lower	$10
D5510	Repair broken complete denture base	$49
D5520	Replace missing or broken teeth	$25
D5610	Repair resin denture base	$25
D5620	Repair cast framework	$49
D5630	Repair or replace broken clasp	$25
D5640	Replace broken teeth - per tooth	$25
D5650	Add tooth to existing partial denture	$30
D5660	Add clasp to existing partial denture	$45
D5710	Rebase complete upper denture	$60
D5711	Rebase complete lower denture	$60
D5720	Rebase upper partial denture	$60
D5721	Rebase lower partial denture	$60
D5730	Reline complete upper denture (chairside)***	$70
D5731	Reline complete lower denture (chairside)***	$70
D5740	Reline upper partial denture (chairside)***	$70
D5741	Reline lower partial denture (chairside)***	$70
D5750	Reline complete upper denture (laboratory)***	$80
D5751	Reline complete lower denture (laboratory)***	$80
D5760	Reline upper partial denture (laboratory)***	$80
D5761	Reline lower partial denture (laboratory)***	$80
D5820	Interim partial denture - upper	$95
D5821	Interim partial denture - lower	$95
D5850	Tissue conditioning - upper	$36
D5851	Tissue conditioning - lower	$36

Crowns/Fixed Bridges - Per Unit

- *Replacement limit 1 every 5 years.*
- *Procedures identified by two asterisks (**) involve the additional cost of noble/ high noble metal.*
- *Cases involving 7 or more crowns and/or fixed bridge units in the same treatment plan require additional $125 member fee per unit in addition to co-pay.*
- *$75 fee per crown/bridge unit above co-pay for porcelain on molars.*

D6210	Pontic - cast high noble metal**	$220
D6211	Pontic - cast predominantly base metal	$220
D6212	Pontic - cast noble metal**	$220
D6240	Pontic - porcelain fused to high noble metal**	$220
D6241	Pontic - porcelain fused to predominantly base metal	$220
D6242	Pontic - porcelain fused to noble metal**	$220
D6750	Crown - porcelain fused to high noble metal**	$220
D6751	Crown - porcelain fused to predominantly base metal	$220
D6752	Crown - porcelain fused to noble metal**	$220
D6780	Crown - 3/4 cast high noble metal**	$220
D6781	Crown - 3/4 cast predominantly base metal	$220
D6782	Crown - 3/4 cast noble metal**	$220
D6790	Crown - full cast high noble metal**	$220
D6791	Crown - full cast predominantly base metal	$220
D6792	Crown - full cast noble metal**	$220
D6930	Recement bridge	$30
D6970	Cast post and core in addition to bridge retainer	$50

Code	Service	Co-payment
D6971	Cast post as part of bridge retainer	$50
D6972	Prefabricated post and core in addition to bridge retainer	$50
D6973	Core build up for retainer, including any pins	$47

Oral Surgery

- *Includes routine post operative visits/treatment.*
- *Surgical removal of impacted teeth not covered unless pathology (disease) exists.*
- *Surgical removal of wisdom tooth/third molar for orthodontic reasons only is not covered.*

D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$15
D7210	Surgical removal of erupted tooth	$30
D7220	Extraction - removal of impacted tooth - soft tissue	$55
D7230	Extraction - removal of impacted tooth - partially bony	$75
D7240	Extraction - removal of impacted tooth - completely bony	$95
D7241	Extraction - removal of impacted tooth - completely bony, with unusual surgical complications	$130
D7250	Surgical extraction - removal of residual tooth roots	$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$30
D7280	Surgical exposure of impacted unerupted tooth for orthodontic reasons	$30
D7285	Biopsy of oral tissue- hard	$50
D7286	Biopsy of oral tissue- soft	$35
D7310	Alveoloplasty in conjunction with extractions - per quadrant	$35
D7320	Alveoloplasty not in conjunction with extractions - per quadrant	$50
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$60
D7971	Excision of pericoronal gingiva	$25

Orthodontics

Benefits cover 24 months of usual & customary orthodontic treatment and 24 months of retention.

D8020	Limited orthodontic treatment of the transitional dentition	$725
D8030	Limited orthodontic treatment of the adolescent dentition	$725
D8040	Limited orthodontic treatment of the adult dentition	$725
D8070	Comprehensive orthodontic treatment of the transitional dentition (full treatment case - including fixed/removable appliances)	$1695
D8080	Comprehensive orthodontic treatment of the adolescent dentition (full treatment case - including fixed/removable appliances)	$1695
D8090	Comprehensive orthodontic treatment of the adult dentition (full treatment case - including fixed/removable appliances)	$1695
D8660	Consultation	$0
D8680	Retention phase (including fee for fixed/removable retainers and monthly visits for 24 months)	$250
D8999	Orthodontic treatment plan and records (pre/post x-rays, photos, study models)	$250

Adjunctive General Services

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9215	Local anesthesia	$0
D9310	Consultation (diagnostic service provided by dentist other than practitioner providing treatment)	$0
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$25
D9630	Medicinal application/irrigation per visit	$15
D9951	Occlusal adjustment - limited	$30
D9952	Occlusal adjustment - complete	$60

Dental Terminology Definitions

These definitions are designed to give you a "layman's understanding" of some dental terminology in order for you to better understand your plan; they are not full descriptions.

Amalgam: A silver filling

Anterior: Teeth that are in the front of the mouth

Bicuspid: Most people have four bicuspid teeth; they are located immediately preceding the molar teeth with two in each quadrant of the mouth.

Bridge: A replacement for one or more missing teeth that is permanently attached to the teeth adjacent to the empty space(s).

Crown: A covering created to place over a tooth to strengthen and/or replace tooth structure. A crown can be made of different of gold (noble, high noble), base metal, porcelain or porcelain and metal.

Endodontics: Procedures that treat disease and injury to the inside of the tooth (the nerve or pulp).

Oral Surgery: Surgery to remove teeth, reshape portions of the bone in the mouth, or biopsy suspect areas of the mouth.

Orthodontics: Braces and other procedures to straighten the teeth.

Periodontics: Procedures related to treatment of the supporting structures of the teeth (gums, underlying bone).

Posterior: Teeth that set towards the back of the mouth.

Primary Teeth: The first set of teeth ("baby" teeth).

Prophylaxis: Teeth cleaning

Prosthodontics: Procedures related to the replacement of teeth with removable appliances like dentures or partial dentures.

Quadrant: One of the four equal sections into which your mouth can be divided (some procedures like periodontics are done in quadrants).

Resin-based Composite: Tooth-colored (white) fillings

SG220D-IP-TX-SOB Member Services (800) 880-1800 5/03

Exclusions and Limitations

Exclusions

1. Services performed by a general dentist or dentist whose practice is limited to providing Specialty Care, not contracted with SafeGuard without prior approval by SafeGuard, (except for out of area emergency services).
2. Any dental services, or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member's dental health, as determined by the SafeGuard general dentist.
3. Any procedures not specifically listed as a covered benefit in the Schedule of Benefits.
4. Dental procedures or services performed solely for cosmetic purposes or solely for appearance.
5. Orthognathic surgery.
6. General anesthesia or intravenous sedation.
7. Any inpatient/outpatient hospital charges of any kind including dentist and/or physician charges, prescriptions or medications.
8. Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen, or damaged due to abuse, misuse, or neglect.
9. Treatment of malignancies, cysts, or neoplasms.
10. Procedures, appliances, or restorations whose main purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders including, but not limited to treatment of myofunctional, myoskeletal, or temporomandibular joint disorders unless otherwise specified as an orthodontic benefit on the Schedule of Benefits.
11. Dental implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services.
12. Precision attachments.
13. Dental procedures initiated prior to the member's eligibility under this Plan or started after the member's termination from the Plan.
14. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
15. Dental services required while serving in the Armed Forces of any country or international authority or relating to a declared or undeclared war or acts of war.
16. Services considered unnecessary or experimental in nature.
17. Dental procedures or appliances for minor tooth guidance or for the control of harmful habits such as thumb sucking and tongue thrusting.

Limitations

1. Procedures identified by * are limited to twice a year unless medically necessary.
2. Procedures identified by ** involve the additional cost of noble/high noble metal.
3. Procedures identified by *** are limited to one every twenty four (24) months.
4. Full-mouth X-rays: Once every three (3) years unless medically necessary.
5. Dentures (full or partial): Replacement only after five (5) years have elapsed following any prior provision of such dentures under a SafeGuard benefit plan. Replacements will be a benefit only if the existing denture is unsatisfactory and can not be made satisfactory as determined by the SafeGuard contracted general dentist.

Exclusions and Limitations

6. Sealants: Plan benefit applies to primary and permanent molar teeth, within four (4) years of eruption.
7. Replacement of any crowns or fixed bridges (per unit) are limited to once every five (5) years.
8. Cases involving seven (7) or more crowns and/or fixed bridge units in the same treatment plan require additional $125 co-payment per unit in addition to co-payment for each crown/bridge unit.
9. There is a $75 co-payment per crown/bridge unit in addition to regular co-payments for porcelain on molars.
10. Surgical removal of wisdom teeth/third molar for orthodontic reasons only is not a covered benefit.
11. Delivery of removable prosthodontics includes up to three (3) adjustments within six (6) months of delivery date of service.
12. Surgical removal of impacted teeth is not a covered benefit unless pathology [disease] exists.
13. The co-payments listed for endodontic procedures do not include the cost of final restoration.

Orthodontic Exclusions & Limitations

1. Orthodontic treatment must be provided by a SafeGuard general dentist in order for the co-payments listed in the Schedule of Benefits to apply. If orthodontic treatment is provided by providing a SafeGuard contracted dentist whose practice is limited to specialty care, the co-payment will be 75% of the SafeGuard contracted dentists usual and customary fees. If orthodontic treatment is provided by a non-contracted general dentist or dentist whose practice is limited to specialty care, no benefit will apply and the member will be responsible for all costs associated with such orthodontic treatment.
2. Plan benefits shall cover twenty-four (24) months of usual and customary orthodontic treatment and an additional twenty-four (24) months of retention. Treatment extending beyond such time periods will be subject to a per-office-visit charge of $25 dollars.
3. The following are not included as orthodontic benefits:
   A. Repair or replacement of lost or broken appliances;
   B. Retreatment of orthodontic cases;
   C. Treatment in progress at inception of eligibility;
   D. Interceptive or Phase I orthodontics;
   E. Changes in treatment necessitated by an accident;
   F. Treatment involving:
      1.) Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia;
      2.) Hormonal imbalances or other factors affecting growth or developmental abnormalities;
      3.) Treatment related to temporomandibular joint disorders;
      4.) Lingually placed direct bonded appliances and arch wires ("invisible braces"); and
      5.) Functional appliances that are used in conjunction with fixed appliances.
4. The retention phase of treatment shall include the construction, placement, and adjustment of retainers.

EL's 2.2-TX

SG220D-IP-TX-S0B Member Services (800) 880-1800 5/03

SafeGuard

SAFEGUARD PLAN
PARA INDIVIDUOS Y FAMILIAS

Agente: 15507

☐ Uno (Ud.): $11.95 ☐ Añual: $143.40

☐ Dos (Ud. + Uno dependiente): $22.00 ☐ Añual: $264.00

☐ Trés o mas: $29.75 ☐ Añual: $357.00

Numero Seguro Social	**Apellido**	**Nombre**	**Inicial**

Dirección de Domicilio			

Ciudad	**Estado**	**Código Postal**	**Teléfono**

Fecha de Nacimiento	**Masculino** ☐ **Femenino** ☐	**Idioma Preferido**	**Indique si tiene impedimento de comunicación**

Opción 1 para oficina dental (Véa el directorio para el numero de esta oficina)	**Opción 2 para oficina dental (Véa el directorio para el numero de esta oficina):**

Información Sobre Los Dependientes

Cónyuge/ Hiho(a)	M/F	Apellido	Nombre	Inicial	Fecha de nacimiento	Estudiante S/N	Discapacidad S/N	N° de Consultorio dental - Opción 1	N° de Consultorio dental - Opción 2

Su pago de prima necesita ser sometida con esta forma de inscripción. Tenemos dos opciónes para pagar su prima. Por favor escoja uno:

1. ☐ **Pago mensual.** Autorizacion que la prima para mi Plan Dental se carge directamente a mi cuenta bancaria de
☐ **CHEQUES** ☐ **AHORRO**
El 15 de cada mes y que el monto sea enviado a SafeGuard. _____
Mi Número de cuenta es _____
Remita un cheque para la primera mes. Habrá un recargo de $15 para cuentas sin fondos.

2. ☐ **Pago añualmente** ☐ **con cheque** (Haga el cheque a nombre de SafeGuard.)
☐ **con tarjeta de credito** ☐ **Visa** ☐ **Mastercard** ☐ **American Express** ☐ **Discover**
Numero de cuenta _____ Día de expiración: _____
Nombre como aparece en la tarjeta: _____

Yo entiendo las condiciones del plan y doy permiso para el plan por el periodo de un (1) año/12 meses.

AUTORIZACIÓN PARA ENTREGAR EXPEDIENTES DENTALES - Por la presente autorizo la entrega para su revisión, o para obtener una copia, de todos los expedientes dentales pertenecientes a mi persona o a un miembro de mi familia, mantenidos por mi dentista de asistencia primaria seleccionada y/o dentista especializado, a SafeGuard y/o cualquier agente o representante designado con fines de tratamiento o atención dental, y para las Evaluaciones de calidad y revisiones de utilización de SafeGuard, las cuales se mantendrán estrictamente confidenciales. Esta autorización seguirá siendo válida durante el plazo de esta cobertura.

Firma: _____ *Fecha*: _____

Envié a aplicación: SafeGuard
Attn: *Plan Individual*
P.O. Box 8095
Laguna Hills, CA 92654-8095