

8220 Irving Road • Sterling Heights, MI 48312 • 844-828-5968 • www.safeguardwisconsin.com

General Information						
<i>This form is required for all eligible employees and dependents who are not enrolling with US Health and Life at the time of initial enrollment and/or the group's open enrollment period.</i>						
Group (Employer) Name _____						
Date of Hire _____						
First Name _____ MI _____ Last _____						
Address _____ City _____ State _____ Zip _____						
Date of Birth _____ Social Security Number _____						
<input type="checkbox"/> Male <input type="checkbox"/> Female						
Daytime Phone Number _____ Email Address _____						
Life Insurance Beneficiary Name _____ Relationship _____						
I decline to enroll for Medical (check all that apply): <input type="checkbox"/> myself <input type="checkbox"/> spouse <input type="checkbox"/> children						
Dependent Information						
Coverage Selection: Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please complete the following for each enrolling individual for dependent life and/or dental if elected by group.						
First Name	MI	Last Name	Relationship	Date of Birth	Sex	Social Security No.
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
Waiver						
I waive the right to enroll with US Health and Life as offered to me by my employer for the following reason (please check one):						
<input type="checkbox"/> I have other coverage through my spouse <input type="checkbox"/> I have other coverage through Medicare						
<input type="checkbox"/> I have individual coverage <input type="checkbox"/> I have no other coverage but choose not to enroll in my employer's plan						
<input type="checkbox"/> Other (explain) _____						
I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent, provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption.						

Employee Signature _____ Date _____

For Office Use Only		
EFF DATE _____	MED _____	CLASS _____
DIVISION # _____	DEN _____	LIFE _____

Excess loss insurance policies and EPO/PPO insurance plans underwritten by US Health and Life Insurance Company.
SafeGuard plans administered by US Health and Life Insurance Company.

© US Health and Life Insurance Company. All rights reserved.