SafeGuard Health Plans, Inc.
SafeHealth Life Insurance Company

Federal COBRA/Cal-COBRA Election Enrollment Form

Federal COBRA applies to Employer groups with 20 or more Employees who are subject to Federal COBRA 1985. The Plan does not administer COBRA for groups subject to this regulation.

The California Continuation Benefits Replacement Act, or "Cal-COBRA", requires Employers with fewer than 20 eligible Employees on at least 50% of its working days during the preceding calendar year, or if the Employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible Employees on at least 50% of its working days during the preceding calendar quarter offer eligible Employees and their families the opportunity for a temporary extension of coverage in certain instances where coverage under the plan would otherwise end. Upon receipt of notice of a qualifying event from either the Employer or the qualified beneficiary, The Plan administers COBRA for groups subject to this regulation.

Coverage **(You must be currently covered in the benefit option(s) selected.)**

- ❑ DHMO Dental Plan — SafeGuard Health Plans, Inc.
- ❑ PPO Dental Plan — SafeHealth Life Insurance Company
- ❑ Indemnity Dental Plan — SafeHealth Life Insurance Company
- ❑ Prepaid Vision Plan — SafeGuard Health Plans, Inc.
- ❑ PPO Vision Plan — SafeHealth Life Insurance Company
- ❑ Indemnity Vision Plan — SafeHealth Life Insurance Company

Check one - This application is for enrollment in:

- ❑ Federal COBRA
- ❑ Cal-COBRA

Qualifying Event

- ❑ Termination of Employment (Termination for gross misconduct is not a qualifying event.)
  - ❑ If termination was because of disability, please indicate.
- ❑ Reduction in Hours
- ❑ Death of Employee
- ❑ Divorce or Legal Separation
- ❑ Entitlement of the Employee to Medicare benefits
- ❑ Termination of child's Dependent status
- ❑ Employer of the Employee files for reorganization under Chapter XI of the Bankruptcy Law or bankruptcy (Federal COBRA only)

Date of Qualifying Event: Month ☐☐ Day ☐☐ Year ☐☐☐☐

General Information

Social Security Number	Last Name	First Name	M.I.	Sex ❑ M ❑ F	Martial Status ❑ Married ❑ Single
Street Address		City (Complete name)	State	Zip Code	County
Home Phone	Date of Birth Month ☐☐ Day ☐☐ Year ☐☐☐☐		Dental Office*		
Former Employer Name			Group No.		

*Subscriber and Dependents enrolled in the SafeGuard Dental DHMO Plan must select a Dental Office.

Shaded area for The Plan office use only

Effective Date Month ☐☐ Day ☐☐ Year ☐☐☐☐ Date Coverage Ends Month ☐☐ Day ☐☐ Year ☐☐☐☐

List below the family member(s) that were covered under your group plan that you wish to continue coverage for under Federal COBRA or Cal-COBRA.

Relationship to Employee	Last Name (if different)	First Name M.I.	Date of Birth	Sex M / F	Medicare Eligible?	Disabled?	Dental Office*
Spouse			Month ☐☐ Day ☐☐ Year ☐☐☐☐	❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	
Dependent Child			Month ☐☐ Day ☐☐ Year ☐☐☐☐	❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	
Dependent Child			Month ☐☐ Day ☐☐ Year ☐☐☐☐	❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	
Dependent Child			Month ☐☐ Day ☐☐ Year ☐☐☐☐	❑ M ❑ F	❑ Yes ❑ No	❑ Yes ❑ No	

*Subscriber and Dependents enrolled in the SafeGuard Dental DHMO Plan must select a Dental Office.

Do you or your family member(s) have other dental/vision coverage? If yes, please complete the following.

❑ Self ❑ Spouse ❑ Dependent Child(ren)

Name of Other Insurance Company		Group Number	
Other Insurance Company's Address	City	State	Zip

All references to the "Plan" herein include SafeGuard Health Plans, Inc. and SafeHealth Life Insurance Company which underwrite or administer the coverage to which this Enrollment Application applies

The reverse side of this application must be completed or your application will be returned to you.

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IMPORTANT!

Please read and retain with your personal records.

Authorization to obtain or release dental/medical information: I consent, on my behalf and on behalf of my enrolled Family Member(s) to the use and disclosure of our dental/medical information by the Plan for purposes of treatment, payment and plan operations. I understand that upon request, the Plan will make available a copy of the statement describing their policies and procedures for preserving the confidentiality of dental/medical information.

RIGHT OF REIMBURSEMENT: I, on my behalf and on behalf of my Family Member(s) listed on this Enrollment Application, hereby agree that in the event any services provided to me or my Family Member(s) and covered by the Plan are the primary financial responsibility of another party, because of other coverage or by the act or omission of another person, I will fully inform the Plan and will execute such assignments, liens or other documents which may be necessary to enable the Plan to recover the value of services and supplies provided in accordance with California law. I further agree that in the event I or any of my Family Member(s) collect benefits or damages from any other party who has primary responsibility for services provided by the Plan, I will immediately reimburse the Plan to the extent of services and supplies received, in accordance with California law.

PLAN REQUIREMENTS: I, on my behalf and on behalf of my Family Member(s) listed on this Enrollment Application, agree to be bound by the benefits, copayments, deductibles, exclusions, limitations and other terms and conditions of the Group Agreement, Policy, Evidence of Coverage or Certificate and as those documents are amended.

BINDING ARBITRATION: I understand and agree that any and all disputes or disagreement between me (including any of my enrolled Family Member(s) or heirs or personal representatives) and the Plan regarding the construction, interpretation, performance or breach of the Evidence of Coverage /Policy/ Certificate, or regarding other matters relating to or arising out of my Plan membership, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, dental/vision/ health care providers, or their agents or employees, are also involved, must be submitted to final and binding arbitration in lieu of a jury or court trial. I understand that, by agreeing to submit all disputes to final and binding arbitration, all parties, including the Plan, are giving up their constitutional right to the extent permitted by law to have their dispute decided in a court of law before a jury. I also understand that disputes that I may have with the Plan involving claims for dental/medical malpractice (that is, whether any dental/medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) are also subject to final and binding arbitration. A more detailed arbitration provision is included in the Evidence of Coverage or Policy/Certificate.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining insurance coverage.

For your protection, California law requires the following disclosure: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I have reviewed the statements on this application and they are true and correct. The Plan reserves the right to rescind or terminate coverage if any material misrepresentation is made in the enrollment application.

Signature	Date Signed

All references to the "Plan" herein include SafeGuard Health Plans, Inc. and SafeHealth Life Insurance Company which underwrite or administer the coverage to which this Enrollment Application applies

CALIFORNIA HEALTHCARE LANGUAGE ASSISTANCE PROGRAM
NOTICE TO INSUREDS

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call the CA Dept. of Insurance at 1-800-927-4357. If you require spoken or written language assistance or would like to inform SafeGuard of your preferred language, please contact us at 1-800-880-1800.

Servicio de Idiomas Sin Costo. Puede obtener la ayuda de un intérprete. Se le pueden leer documentos y enviar algunos en español. Para recibir ayuda, llame al Departamento de Seguros de California al 1-800-927-4357. Si necesita asistencia oral o escrita con un idioma, o si desea informar a SafeGuard su idioma de preferencia, comuníquese con nosotros al 1-800-880-1800.

免費語言服務。您可獲得免費口譯服務。您可要求翻譯員向您口譯文件，或可要求向您發回文件的中文譯本。如需協助，請致電加州保險部熱線 1-800-927-4357。如欲獲取口頭或書面語言協助，或希望告知 SafeGuard 您的首選語言，請致電 1-800-880-1800 聯絡我們。

Անվճար թարգմանչական ծառայություններ: Ձեզ կտրամադրվի հայերենի թարգմանիչ, որի օգնությամբ կարող եք հայերենով կարդալ փաստաթղթերը: Հարցերի դեպքում զանգահարեք Կալիֆորնիայի Ապահովագրական Դեպարտամենտ 1-800-927-4357 հեռախոսահամարով: Եթե Ձեզ անհրաժեշտ է բանավոր կամ գրավոր թարգմանչական ծառայություն կամ կցանկանայիք տեղեկացնել SafeGuard ընկերությանը Ձեր նախընտրած լեզվի մասին, խնդրում ենք զանգահարել մեզ 1-800-880-1800 հեռախոսահամարով:

لا تتوفر خدمات ترجمة بتكلفة. يمكنك الاتصال بمترجم والحصول على خدمة قراءة المستندات باللغة العربية. لمزيد من المساعدة، اتصل بقسم التأمينات التابع لـ CA على الرقم 1-800-927-4357. وإذا كنت تريد الحصول على مساعدة بشأن اللغة المنطوقة أو المكتوبة أو كنت ترغب في إبلاغ SafeGuard بلغتك المفضلة، فيُرجى الاتصال بنا على الرقم 1-800-880-1800.

សេវាបកប្រែដោយឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែម្នាក់ និងអាចឱ្យគេអានឯកសារនានាឱ្យអ្នកស្តាប់ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទទៅ ក្រសួងធានារ៉ាប់រង នៃរដ្ឋកាលីហ្វ័រញ៉ា (CA Dept. of Insurance) តាមលេខ 1-800-927-4357 ។ ប្រសិនបើអ្នកត្រូវការជំនួយបន្ថែមផ្នែកភាសា ជាការសរសេរ ឬជាការនិយាយក្តី ឬចង់ជូនដំណឹងទៅផ្នែក ការពារសុវត្ថិភាព (SafeGuard) អំពីភាសាដែលអ្នកចង់បាននោះ សូមទាក់ទងមកយើងតាមលេខ 1-800-880-1800 ។

Pab txhais lus dawb. Koj muaj cuabkav hais kom muaj tus neeg txhais lus thiab muab cov lus nyeem ua lus Hmoob rau koj. Xav tau txais kev pab, hu rau CA Dept. of Insurance ntawm 1-800-927-4357. Yog koj toobkam kom luag hais ua lus lossis sau ua ntawv pab lossis yog xav hais rau SafeGuard paub txog hom lus koj toobkam kom luag siv rau koj, mas koj yuav tsum hu rau 1-800-880-1800.

無料の通訳サービス。通訳を通して日本語で文書を読み上げてもらうことができます。サービスの利用をご希望の方は、カリフォルニア州保険庁 1-800-927-4357 までお問い合わせください。音声あるいは書面による言語サービスが必要な方、もしくはご希望の言語をSafeGuard へ通知したい方は、1-800-880-1800 へお電話ください。

무료 통역 서비스. 통역자가 문서를 한국어로 읽어드릴 수 있습니다. 도움이 필요하시면, 전화번호 1-800-927-4357로 캘리포니아 보험국에 연락하여 주십시오. 통역이나 번역 관련 도움이 필요하시거나 SafeGuard 에 원하시는 언어를 알리려면, 1-800-880-1800으로 연락하여 주십시오.

سرویس های ترجمه رایگان. شما می توانید مترجم و اسنادی را به زبان فارسی برای مطالعه دریافت کنید. برای راهنمایی، با بخش بیمه کالیفرنیا 1-800-927-4357 تماس بگیرید. درصورتیکه به راهنمای زبان نوشتاری یا گفتاری نیاز دارید یا مایلید SafeGuard (محافظ زبان) ترجیحی خود را مطلع نمایید، لطفاً با شماره ما 1-800-880-1800 در آمریکا تماس بگیرید.

بلا معاوضہ مترجم دی خدمات مل سکدی اے- تُسی ایک مترجم دی خدمات حاصل کرسکدے او جو توڈے واسطے دستاویزات پنجابی وچ پڈ سکدا اوے- مدد واسطے، اے نمبر 1-800-927-4357 پہ CA ڈیپارٹمنٹ برائے انشورنس نال گال کرو- اگر تُسی بولنے یا لکھنے واسطے مدد چاہتے ہو یا SafeGuard نوں دوسری کوئی زبان فرمائش کرنا چاہدے ہو، تو برائے کرم سانوں اے نمبر 1-800-880-1800 تے گال کرو-

Бесплатные услуги устного перевода. Вы можете воспользоваться услугами переводчика, который прочитает вам документы на русском языке. Чтобы получить помощь, позвоните на горячую линию Департамента страхования (CA Dept. of Insurance) 1-800-927-4357. Если вам необходимы услуги по оказанию помощи в письменном или устном переводе, или вы хотите сообщить SafeGuard о языке, который вы предпочитаете, пожалуйста, позвоните нам по телефону 1-800-880-1800.

Libreng Serbisyo sa Pagsasalin. Maaari kang kumuha ng tagasalin para basahin sa iyo ang mga dokumento sa wikang Tagalog. Para ikaw ay matulungan, tawagan kami sa CA Dept. of Insurance sa 1-800-927-4357. Kung kailangan mo ng tulong upang makapagsalita o makapagsulat sa iyong wika o kung gusto mong ipaalam sa SafeGuard ang wikang gusto mong gamitin, maaari lamang na tawagan kami sa 1-800-880-1800.

Dịch vụ thông dịch miễn phí. Quý vị có thể tìm một thông dịch viên và nhờ đọc tài liệu này cho quý vị bằng tiếng Việt. Để được giúp đỡ, gọi cho Ban Bảo Hiểm CA tại số 1-800-927-4357. Nếu quý vị cần giúp đỡ bằng lời nói hoặc viết hoặc muốn báo cho SafeGuard về ngôn ngữ quý vị muốn nói, xin liên lạc với chúng tôi tại số 1-800-880-1800.