

DENTIST NOMINATION FORM

(This is not an enrollment form)



SafeGuard

I would like to nominate my dentist for the SafeGuard provider network.

Date: _____

Employer or Group Name: _____

Employee's Name: _____

Patient's Name (if different from Employee's name): _____

Relationship to Employee (i.e. spouse, child, self, etc.): _____

City: _____ County: _____

Home Phone: _____ Work: _____

Name of plan in which Member is enrolling: _____

Effective Date of Plan (mm-dd-year): _____

DENTIST INFORMATION

Office Name: _____

Office Manager: _____

Doctor's Name: _____

Address: _____ Suite: _____

City: _____ Zip: _____

County: _____

Phone: _____ Fax: _____

Specialty: _____

Please submit completed form to:

Healthcare National Marketing, Inc.
4613 US Hwy 19
New Port Richey, FL 34652
Fax: 727-816-9057