SUPERIOR DENTAL CARE
ENROLLMENT or CHANGE APPLICATION

Company Name: _____ **Group #:**_____ **Subgroup #:**_____

Employee Name: _____ SS#: _____

_____
Address City State Zip Code

_____ ☐ Male ☐ Female Date of Birth: _____
Home Phone # Work Phone # E-Mail Address

Superior Direct Connect - Once your group is enrolled and effective, go to www.superiordental.com, click on Get Connected! **and sign up to access your account and personal benefit information.**

REASON FOR FORM:

- ☐ New Enrollment
- ☐ Subgroup Change
- ☐ Address Change
- ☐ Open Enrollment
- ☐ Enrollee Termination & Reason_____
- ☐ Delete Dependent & Reason_____
- ☐ Add Dependent & Reason_____
- ☐ Other_____
- ☐ COBRA Continuation/Conversion
- ☐ Waive Coverage
- ☐ Marriage Date_____
- ☐ Divorce Date_____

Effective Date of Action: _____

Enrolling in the Following Dental Plan:

☐ **Preferred** ☐ **Choice** ☐ **Direct**

Choose one of the following if it applies to your group:

☐ **Core Plan** ☐ **Enhanced Plan**

Dependent Information: Complete the information below for each dependent to be **ADDED** or **CHANGED**.

Full Name	Relationship	Sex	Birth Date
			/ /
			/ /
			/ /
			/ /
			/ /
			/ /

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Contract issued to my employer by Superior Dental Care, Inc. I understand that the benefits for which I (we) will be eligible are in accordance with those described in the Master Group Contract and any changes provided therein. I understand that certain services may require a co-payment payable by me (or my dependents) directly to the provider of such services. I further understand that covered services may be obtained through any licensed dentist and also that certain services may require a co-payment payable by me (or my dependents) directly to the provider of such services. Superior Dental Care also offers a network only plan. Please refer to the dental contract available through your employer for clarifications on the dental plan currently in place. I authorize my employer to deduct the necessary dental service fees, if any, from my wages or salary, with the understanding that he acts as my agent in all dealings with Superior Dental Care, Inc., and that all acts performed by him and all notices given to him in such dealings are binding upon me, as not prohibited by statute or regulation. In the event that this Application for Coverage is accepted, I authorize my dentist to give, upon request, any information concerning the condition or treatment of any person included under such coverage whenever such information is considered necessary by Superior Dental Care, Inc. for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed on Superior Dental Care, Inc. by state or federal statutes. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Is your spouse employed? ☐ Yes ☐ No Does he/she carry any other type of dental coverage? ☐ Yes ☐ No If yes, please complete the following:

Insurance Company:_____ Employer Name: _____

Employer Address:_____ SS# / policy #:_____/_____

Group Number:_____ Individuals Covered:_____

Enrollee Signature:_____ **Date:**_____

Approved by (Group Administrator):_____ **Date:**_____