SUPERIOR DENTAL CARE
EMPLOYEE ENROLLMENT FORM

LEADING THE WAY IN DENTAL BENEFITS

General Information:

Effective Date of Action:_____

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

Employee Name:_____ SS#: _____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone #:_____ Alternate Phone #:_____ E-Mail:_____

Date of Birth:_____ ☐ Male ☐ Female

Enrolling in the following Dental Plan:

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

Choose one the following if it applies to your group: ☐ Core Plan or ☐ Enhanced Plan

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 the Form:

☐ New Enrollment / ☐ Open Enrollment

☐ Subgroup Change

☐ COBRA Continuation/Conversion

☐ Waive Coverage

☐ Add / ☐ Delete Dependent & Reason: _____

☐ Marriage / ☐ Divorce Date: _____

☐ Enrollee Termination & Reason: _____

☐ Other: _____

Dependent Information:

Full Name	*Relationship*	*Gender*	*Birth Date*	*Coordination of Benefits*
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N
				Y / N

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. 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 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 for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed on Superior Dental Care 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.

Other Dental Coverage (if you circled 'Y' in the Coordination of Benefits section above for any of the dependents listed, please complete this section):

Does your spouse carry any other type of dental coverage / Coordination of Benefits? ☐ Yes ☐ No If yes, please complete the following: Policy #:_____

Employer Name:_____ Insurance Company:_____

Employer Address:_____ SS #:_____ Birthdate:_____

City:_____ State:_____ Zip:_____ Individuals covered by spouse:_____

Signatures:

Enrollee Signature:_____ **Date:**_____

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

October 2011