SUPERIOR DENTAL CARE ALLIANCE
GROUP APPLICATION

A

General Information:

Name of Group: ______________________ # of Eligible Employees: __________

Address: ______________________ Group Tax ID#: __________

City/State/Zip:______________________ Phone:__________

County: ______________________ Fax: __________

B

Contacts: (please include titles)

Administration: __________ Title: __________ Email: __________

Enrollment: __________ Title: __________ Email: __________

Billing (name & location): ______________________

Electronic Enrollment: □ Yes □ No

Automatic Deduction of Fees / Premiums: □ Yes □ No If yes, please attach a voided check.

Electronic Billing: □ Yes □ No Email: __________

C

Eligibility Information:

Dependents will be covered through the end of the □ **birth month** or □ **calendar year**. **Please check either birth month or calendar year and complete the following age limits:**

-Primary dependents covered to age: __________ **AND**

-Full-time students covered to age: __________ **OR** IRS dependents covered to age: __________

D

Plan Design & Rates: **Plan Number:_______** **Effective Date:_______** **Renewal Date:_______**

The Preferred Plan		The Choice Plan			The Direct Plan	ASO
	Core		In Network	Out of Network	Admin Fee: $__________	Admin Fee:
Preventive	______%	Preventive	______%	______%	Reimbursement Schedule	$__________
Basic	______%	Basic	______%	______%	Level 1__________	
Major	______%	Major	______%	______%	Level 2__________	
Deduct	$______	Deduct	$______	$______	Level 3__________	
Contract Max	$______	Contract Max	$______	$______	Level 4__________	
Ortho	______%	Ortho	______%	______%	Ortho Max $__________	
Ortho Max	$______	Ortho Max	$______	$______	Contract Max $__________	
Max Advantage	$______ yr 2					
Contract Max	$______ yr 3					
Rates		Rates			Funding Rates	Funding Rates
Employee	$______	Employee	$______		Employee $______	Employee $______
EE+Spouse	$______	EE+Spouse	$______		EE+Spouse $______	EE+Spouse $______
EE+Child	$______	EE+Child	$______		EE+Child $______	EE+Child $______
EE+Children	$______	EE+Children	$______		EE+Children $______	EE+Children $______
EE+Family	$______	EE+Family	$______		EE+Family $______	EE+Family $______

Superior EyeCare *(Powered by EyeMed)* □ **Access Plan C-O (low plan)** □ **Access Plan H-10 (high plan)**

Contribution Level: Employer Pays: __________ Employee Pays: __________

Chamber Plan: □ Yes □ No If Yes, name of chamber: __________

Note: All chamber information will be verified with designated chamber before group is installed.

E

Broker Information: Name: __________ ***Firm: __________

Address: __________ Phone: __________

City/State/Zip: __________ Fax: __________

Email Address: __________ Tax ID: __________

Is the firm incorporated? □ Yes □ No

***** Commission will be paid to the firm unless otherwise agreed upon.**