SUPERIOR DENTAL CARE
EMPLOYEE ENROLLMENT FORM

Superior Dental Care®
A Medical Mutual® Company

LEADING THE WAY IN DENTAL BENEFITS

Company Name: _____ **Effective Date of Action:** _____

Employee Name: _____ Group #: _____ Subgroup #: _____

Address: _____ ☐ Male ☐ Female

City: _____ State: _____ Zip: _____ County: _____ Home Phone #: _____ Alt Phone #: _____

Date of Birth: _____ SS#: _____ E-Mail: _____

Which **dental** plan number are you enrolling?: #_____ Are you enrolling in **vision***?: ☐ Yes ☐ No

To be eligible for one of the Superior Vision plans, your group must first select an SDC dental plan.

Reason for the Form:

☐ New Enrollment / ☐ Open Enrollment ☐ Add / ☐ Delete Dependent & Reason: _____

☐ Subgroup Change ☐ Marriage / ☐ Divorce Date: _____

☐ COBRA Continuation/Conversion ☐ Enrollee Termination & Reason: _____

☐ Waive Coverage ☐ Other: _____

Dental	*Vision**	*Full Name*	*Relationship*	*Gender*	*Birth Date*	*Other Dental Insurance*
Y / N	Y / N					Y / N
Y / N	Y / N					Y / N
Y / N	Y / N					Y / N
Y / N	Y / N					Y / N
Y / N	Y / N					Y / N
Y / N	Y / N					Y / N

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

Are you, your spouse, or any dependents also covered under another dental policy? ☐ Yes ☐ No If yes, please complete the following: Policy #: _____

Employer Name: _____ Insurance Company: _____

Employer Address: _____ SS #: _____ Birthdate: _____

City: _____ State: _____ Zip: _____ Individuals covered: _____

Signatures:

Enrollee Signature: _____ **Date:** _____

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

Superior Direct Connect - Once your group is enrolled and effective, go to superiordental.com and sign up to access your account and personal benefit information.

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Contract/Policy issued to my employer by Superior Dental Care (SDC). I understand the benefits for which I and my dependents are eligible under this Policy. I understand certain services may require a copayment or deductible payable by me or my dependents directly to the provider of services. 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 the plan 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. I waive the dentist-patient privilege and authorize my dentist to give SDC, its agents and representatives, any information concerning any claims for reimbursement for covered services of any person under this coverage. In the absence of fraud, all statements under this application are considered representations and not warranties.

OHIO FRAUD NOTICE: 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.

KENTUCKY FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

INDIANA FRAUD NOTICE: Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

7.12.2019