SUPERIOR DENTAL CARE
EMPLOYER GROUP APPLICATION

LEADING THE WAY IN DENTAL BENEFITS

General Information:

Total Employees: _____

Name of Group: _____ # of Eligible Employees: _____

Address: _____ Group Tax ID#: _____

City/State/Zip: _____ Phone: _____

County: _____ SIC Code: _____ Fax: _____

Contacts: (please include titles)

Administration: _____ Title: _____ Email: _____

Enrollment: _____ Title: _____ Email: _____

Superior Direct Connect: _____ Title: _____ Email: _____

To sign up for Superior Direct Connect, our online account management system, please go to our website at superiordental.com

Billing: _____ Title: _____ Email: _____

□ Automatic Deduction of Fees / Premiums, please complete the form on the back and attach a voided check.

Eligibility Information:

Dependents are covered to the maximum age of: _____ (SDC permits up to age 26 *through the end of the* ***birth month***).

Contribution Level:

Employer Pays: _____ EE Pays: _____

Effective Date: _____

Renewal Date: _____

SDC-Kids plan:

□ Low Plan

□ High Plan

Network Option:

□ Open Access (In & Out of Network)

□ Point of Service

□ Network Only

Funding Option:

□ Fully-Funded

□ Self-Funded

Superior Vision*:

Plan #: _____

□ Tied to Dental

□ Employer Paid

□ Voluntary

Based on the SDC rate sheet and plan options available, please complete the information below. If one plan has been selected, please list the plan information in the first column below. If 2 or 3 plans are selected, please use the columns below starting with the first.

Plan design:

	Plan: _____	Plan: _____	Plan: _____
	In Network / Out of Network	In Network / Out of Network	In Network / Out of Network
Preventive	_____% / _____%	_____% / _____%	_____% / _____%
Basic	_____% / _____%	_____% / _____%	_____% / _____%
Major	_____% / _____%	_____% / _____%	_____% / _____%
Contract Maximum	$_____	$_____	$_____
Deductible	$_____	$_____	$_____
Copay	$_____	$_____	$_____
Ortho	_____% / _____%	_____% / _____%	_____% / _____%
Ortho Max	$_____	$_____	$_____

Admin fee (if Self-Funded):

ASO Admin Fee: $_____

or

Direct Admin Fee: $_____

Reimbursement Schedule:

Level 1 _____

Level 2 _____

Level 3 _____

Level 4 _____

Ortho Max $_____

Contract Max $_____

With SDC's Network? □ Yes □ No

Vision Rates*:

Employee	$_____
EE+Spouse	$_____
EE+Child(ren)	$_____
Family	$_____

Dental Rates:

Employee $_____	Employee $_____	Employee $_____	Employee $_____
EE+Spouse $_____	EE+Spouse $_____	EE+Spouse $_____	EE+Spouse $_____
EE+Child(ren) $_____	EE+Child(ren) $_____	EE+Child(ren) $_____	EE+Child(ren) $_____
Family $_____	Family $_____	Family $_____	Family $_____

*Your group must be enrolled in an active SDC dental plan in order to be eligible for a Superior Vision plan.

Approved Association/Chamber Name (if applicable): _____

SDC offers plans to select chambers and associations. For a complete listing, please contact SDC. *Note: All association/chamber information will be verified with designated chamber before group is installed.*

Broker Information:

**Firm Name: _____

Selling Agent Name: _____ Tax ID: _____ NPN #: _____

Selling Agent Email: _____ Address: _____

Servicing Agent Name: _____ City/State/Zip: _____

Servicing Agent Email: _____ Phone: _____ Fax: _____

****Commission will be paid to the firm.**

If this is your first sale with SDC, please complete and return the Producer Appointment Information Form. Please ask your sales representative for details. 7.27.17