SUPERIOR DENTAL CARE
EMPLOYER GROUP APPLICATION

Superior Dental Care® — A Medical Mutual® Company

LEADING THE WAY IN DENTAL BENEFITS

General Information:

Name of Group: ______________________
Address: ______________________
City/State/Zip: ______________________
County: ______________________ SIC Code: ______________________
Total Employees: ______________________
# of Eligible Employees: ______________________
Group Tax ID#: ______________________
Phone: ______________________
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

Max Advantage:

☐ Yes

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	$________	$________	$________
Max Adv Yr. 2	$________	$________	$________
Max Adv Yr. 3	$________	$________	$________
Deductible	$________	$________	$________
Copay	$________	$________	$________
Ortho	____% / ____%	____% / ____%	____% / ____%
Ortho Max	$________	$________	$________

Vision Rates*:		**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 $________

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

*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:

Selling Agent Name: ______________________
Selling Agent Email: ______________________
Servicing Agent Name: ______________________
Servicing Agent Email: ______________________
**Firm Name: ______________________
Tax ID: ______________________ NPN #: ______________________
Address: ______________________
City/State/Zip: ______________________
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. 6.7.19

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT

Company Name:____ **Group Number:**____________________

*We hereby authorize **SUPERIOR DENTAL CARE** to initiate debit entries to our account indicated below at the financial institution named below.*

Name on Account:____

Account Number:____

Type of account (circle one): CHECKING SAVINGS

Financial Institution Name:____

Address:____

Routing and Transit Number:____

Please attach a copy of a voided check to ensure proper processing.

*This authorization will remain in full force and effect until **SUPERIOR DENTAL CARE** has received written notification of **ANY** and **ALL** changes **30 DAYS PRIOR** to change date and in such a manner as to afford **SUPERIOR DENTAL CARE** and **BANK** to act upon it.*

NAME OF AUTHORIZED PERSON:____

SIGNATURE:____ **DATE:**______________________

Please return to:

Superior Dental Care
Attn: Finance Department
6683 Centerville Business Parkway
Centerville, OH 45459

6.7.19