SUPERIOR DENTAL CARE ALLIANCE
ENROLLMENT or CHANGE APPLICATION

A

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

Employee Name: _____ SS#: _____

_____
Address City State Zip Code

_____ ☐ Male ☐ Female Date of Birth:_____
Home Phone # Work Phone #

Effective Date of Action: _____ **Enrolling in the Following Dental Plan:** ☐ **Preferred** ☐ **Choice** ☐ **Direct**

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

REASON FOR FORM:

☐ New Enrollment ☐ Open Enrollment ☐ Marriage Date_____ ☐ Divorce Date_____
☐ Subgroup Change ☐ COBRA Continuation/Conversion ☐ Add Dependent & Reason_____
☐ Address Change ☐ Waive Coverage ☐ Delete Dependent & Reason_____
☐ Other_____ ☐ Enrollee Termination & Reason_____

B

Dependent Information: Complete the information below for each dependent to be **ADDED** or **CHANGED**. Note: Dependent's principal place of residence must be within Superior's service area and with the employee unless other arrangements have been made with Superior.

Full Name	Relationship	Sex	Birth Date
			/ /
			/ /
			/ /
			/ /
			/ /
			/ /

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 Alliance. 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 further understand that if applying for The Preferred Plan, covered services must be obtained through a participating dentist (except for emergencies) and also 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 if applying for The Choice Plan or The Direct Plan, 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. 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 Alliance, 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 Alliance for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed on Superior Dental Care Alliance 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.

C

Is your spouse employed? ☐ Yes ☐ No Does he/she carry any other type of dental coverage? ☐ Yes ☐ No If yes, please complete the following:

Insurance Company:_____ Employer Name: _____

Employer Address:_____ SS# / policy #:_____/_____

Group Number:_____ Individuals Covered:_____

D

Enrollee Signature:_____ Date:_____

Approved by (Group Administrator):_____ Date:_____

Superior Processed by:_____ Date:_____