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 Plan:**

☐ **Preferred**	☐ **Choice**
☐ **Direct**	☐ **ASO**

Choose one of the following if it applies to your plan: ☐ **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 except for emergencies, covered services must be obtained through a participating 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:____________

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