SUPERIOR DENTAL CARE
ENROLLMENT or CHANGE APPLICATION

A

Company Name: Delaware County Group #:__________ Subgroup #:__________

Employee Name: ______________________ SS#: ______________________

Address ______ City ______ State ______ Zip Code ______

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

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.

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, Inc. 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 understand 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, Inc., 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, Inc. for the proper disposition of a claim submitted for payment or in fulfillment of obligations imposed on Superior Dental Care, Inc. 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:__________