



**SUPERIOR DENTAL CARE  
EMPLOYEE ENROLLMENT FORM**

**LEADING THE WAY IN DENTAL BENEFITS**

Company Name: \_\_\_\_\_ **Effective Date of Action:** April 1, 2022

Employee Name: \_\_\_\_\_ Group #: D9795 Subgroup #: \_\_\_\_\_

Address: \_\_\_\_\_ Which dental plan number are you enrolling?: # \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Are you enrolling in vision\*?:  Yes  No

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Male  Female Home Phone #: \_\_\_\_\_ Alt Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

*\*To be eligible for one of the Superior Vision plans, your group must first select an SDC dental plan.*

**Reason for the Form:**

- New Enrollment /  Open Enrollment  Add /  Delete Dependent & Reason:
- Subgroup Change  Marriage /  Divorce Date:
- COBRA Continuation/Conversion  Enrollee Termination & Reason:
- Waive Coverage  Other:

Dental	Vision*	Full Name	Relationship	Gender	Birth Date	Other Dental Insurance
-	No					-
-	No					-
-	No					-
-	No					-
-	No					-
-	No					-

*\*To be eligible for one of the Superior Vision plans, your group must first select an SDC dental plan.*

**Other Dental Coverage** (if you circled 'Y' in the Other Dental Insurance section above for any of the dependents listed, please complete this section):

Are you, your spouse, or any dependents also covered under another dental policy?  Yes  No If yes, please complete the following: Policy #: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Employer Address: \_\_\_\_\_ SS #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Individuals covered: \_\_\_\_\_

**Signatures:**

**Enrollee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Approved by (Group Administrator):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Superior Direct Connect** - Once your group is enrolled and effective, go to [superiordental.com](http://superiordental.com) and sign up to access your account and personal benefit information.

On behalf of myself and any dependents listed above, I hereby apply for coverage under the Master Group Contract/Policy issued to my employer by Superior Dental Care (SDC). I understand the benefits for which I and my dependents are eligible under this Policy. I understand certain services may require a copayment or deductible payable by me or my dependents directly to the provider of 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 the plan 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. I waive the dentist-patient privilege and authorize my dentist to give SDC, its agents and representatives, any information concerning any claims for reimbursement for covered services of any person under this coverage. In the absence of fraud, all statements under this application are considered representations and not warranties.

**OHIO FRAUD NOTICE:** 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.

**KENTUCKY FRAUD NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

**INDIANA FRAUD NOTICE:** Any person who knowingly and with intent to defraud an insurer files an application for insurance containing any false, incomplete, or misleading information commits a felony.

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