



# ENROLLMENT or CHANGE APPLICATION

On all changes, please fill in the employee name and Social Security number.  
**Please print legibly or type.**

**COMPANY NAME:** \_\_\_\_\_ **GROUP #** \_\_\_\_\_ **SUBGROUP#** \_\_\_\_\_

EMPLOYEE NAME \_\_\_\_\_

SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK PHONE # \_\_\_\_\_

**REASON FOR FORM:**

<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> ADD DEPENDENT & REASON _____
<input type="checkbox"/> OPEN ENROLLMENT	_____
<input type="checkbox"/> COBRA CONTIN. /CONVERSION	_____
<input type="checkbox"/> ENROLLEE TERMINATION & REASON _____	<input type="checkbox"/> DELETE DEPENDENT & REASON _____
_____	_____
<input type="checkbox"/> ADDRESS CHANGE	<input type="checkbox"/> MARRIAGE DATE _____
<input type="checkbox"/> OTHER _____	<input type="checkbox"/> DIVORCE DATE _____
_____	<input type="checkbox"/> SUBGROUP CHANGE
	<input type="checkbox"/> WAIVE COVERAGE

Male  Female Date of Birth \_\_\_\_\_

MARITAL STATUS:  Single  Married

**EFFECTIVE DATE OF ACTION:** \_\_\_\_\_

DEPENDENT INFORMATION	FULL NAME	RELATIONSHIP	SEX	BIRTH DATE
Complete the information at the right for each dependent to be <b>ADDED</b> or <b>CHANGED</b> . Note: Dependent's principal place of residence must be within Superior Dental Care's service area and with the employee unless other arrangements have been made with SDC.				/ /
				/ /
				/ /
				/ /
				/ /
				/ /

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: \_\_\_\_\_

Social Security # / Policy #: \_\_\_\_\_ / \_\_\_\_\_ Group # \_\_\_\_\_

Individuals Covered: \_\_\_\_\_

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

ENROLLEE SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

APPROVED BY (Group Administrator): \_\_\_\_\_ Date: \_\_\_\_\_

SDC PROCESSED BY: \_\_\_\_\_ Date: \_\_\_\_\_